Summer 1991

Jefferson Alumni Bulletin – Volume XL, Number 4, Summer 1991

Jefferson

MEDICAL COLLEGE
ALUMNI BULLETIN
Summer 1991

Calendar

September 24, Tuesday
Alumni reception at the meeting of the
American Academy of Otolaryngology—Head and Neck Surgery
6:00 P.M., Westin Hotel
Kansas City

September 26, Thursday
Alumni Association Executive Committee meeting

September 27, Friday
Alumni reception at the meeting of the
American Academy of Family Physicians
5:30 P.M., Washington Hilton and Towers
Washington, D.C.

October 3, Thursday
Reception for University President Paul C. Brucker, M.D.
New York City

October 15, Tuesday
Alumni reception at the meeting of the
American Academy of Ophthalmology
6:00 P.M., Disneyland Hotel
Anaheim, California

October 17–18, Thursday and Friday
CARDEZA FOUNDATION FIFTIETH ANNIVERSARY SCIENTIFIC SYMPOSIUM
"FRONTIERS IN HEMATOLOGY" (open to the public) Solis-Cohen Auditorium
Thur. 2:00–2:45 P.M. Michael A. Gimbrone, Jr., M.D.,
"Endothelium-Dependent Mechanisms in Inflammation and Atherosclerosis"
Thur. 4:15–5:00 P.M. Robert D. Rosenberg, M.D., Ph.D.,
"The Interaction of the Vessel Wall with the Hemostatic System"
Fri. 8:30–9:15 A.M. Harvey F. Lodish, Ph.D.,
"Structure, Activation, and Significance of the Erythropoietin Receptor"
Fri. 10:30–11:15 A.M. Lewis C. Cantley, Ph.D.,
"Oncogenes, Growth Factors, and Signal Transduction"
Fri. 11:30–12:15 Robert C. Gallo, M.D. '63,
"Human Retroviruses: The Second Decade"

October 22, Tuesday
Alumni reception at the meeting of the
American College of Surgeons
6:00 P.M., Fairmont Hotel
Chicago

October 25, Friday
President's Club Dinner
Ritz-Carlton Hotel

October 26, Saturday
Alumni reception at the meeting of the
American Society of Anesthesiologists
6:00 P.M., San Francisco Hilton Hotel
San Francisco

October 29, Tuesday
Alumni reception at the meeting of the
American Academy of Physical Medicine and Rehabilitation
7:00–9:00 P.M., Washington Sheraton Hotel
Washington, D.C.

November 7, Thursday
Medical Humanities and Social Sciences Lecture
(open to the public)
Lester Wright, M.D., M.P.H.
Director, Division of Public Health,
Delaware Health and Social Services
"The Health of the Public: Keeping People on Both Sides of the Track Healthy"
4:30 P.M., Alumni Hall

November 21, Thursday
Alumni Association Executive Committee meeting

December 3, Tuesday
Alumni reception at the meeting of the
Radiological Society of North America
5:00 P.M., McCormick Hotel
Chicago

December 4, Wednesday
Career Day for Sophomores

December 9, Monday
Alumni reception at the meeting of the
American Academy of Dermatology
6:00 P.M., Loews Anatole Hotel
Dallas

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MEDICAL COLLEGE ALUMNI BULLETIN

Volume XL, Number 4 Summer 1991

On the front cover:
The Bluemle Life Sciences Building from the southwest. See page **28**
photo by Dave Super

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On the back cover:
A sweeping view of Philadelphia, with the Liberty Place towers to the right and Jefferson Alumni Hall to the left, from a stairwell of the Bluemle Life Sciences Building. See page **28**
photo by Dave Super

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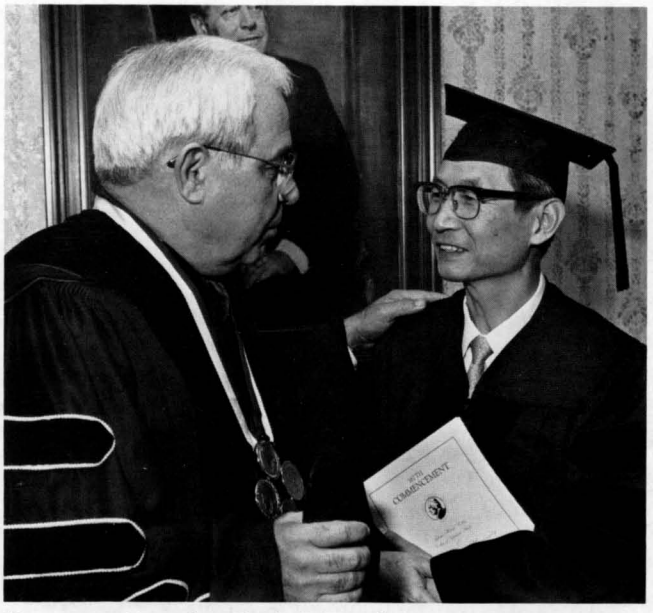
Commencement 1991



University President Paul C. Brucker, M.D. welcomes Chen Minzhang, who was awarded an honorary degree of Doctor of Letters. In his speech at Commencement, Dr. Chen lauded the cooperation between Jefferson and foreign universities.

Minister of Public Health of the People's Republic of China, Dr. Chen is the country's highest-ranking health official and leading spokesman on medical education and science. He is a specialist in the early diagnosis of gastric cancer, the application of the endoscopic retrograde cholangiopancreatogram, and the diagnosis of pancreas and biliary duct diseases.

As Minister, Dr. Chen has emphasized the improvement of the three-tier primary health network, and the education of the rural health work force, making China's health care system a model for other less-industrialized nations. The country has reached child immunization targets before the globally accepted goal. Many health indicators now compare favorably to those of industrialized countries.

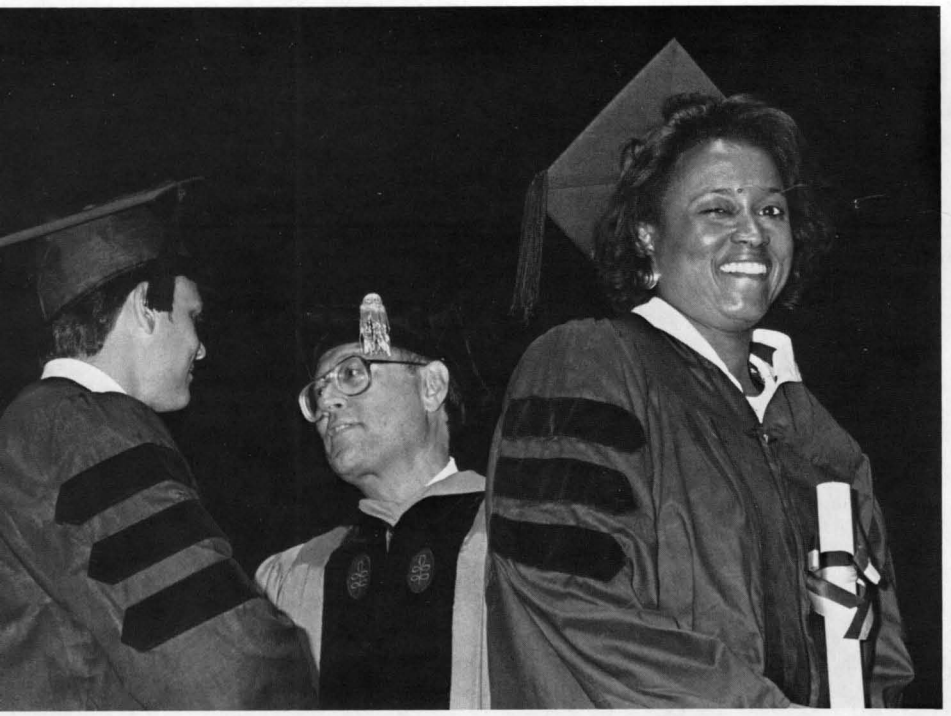
In 1989 Dr. Chen was elected President of the World Health Assembly's forty-second annual meeting. This year, the World Health Organization awarded him its Health-for-All Medal.

James F. Burke, '36; his daughter, Margaret Linda Burke, '91; and her brother, James Francis Burke, Jr., '66, Clinical Professor of Medicine

Robert J. Glaser, M.D., who received an honorary Doctor of Science degree, talks with James W. Stratton, Chairman of the Board.

Dr. Glaser is Director for Medical Science at the Lucille P. Markey Charitable Trust. He began his career at Washington University in St. Louis, studying streptococcal infections and rheumatic fever and becoming Associate Dean of the School of Medicine. After serving as Vice-President for Medical Affairs at Stanford University, Dr. Glaser turned his attention to medical philanthropy, joining the Henry J. Kaiser Family Foundation as President and Chief Executive Officer. In 1968–69, he chaired the Association of American Medical Colleges.

Jennifer L. Sabol, '90; her grandfather, Peter A. Justin, '31; her sister, Mary E. Sabol, '91; and her mother, Louise Justin Sabol, M.D.



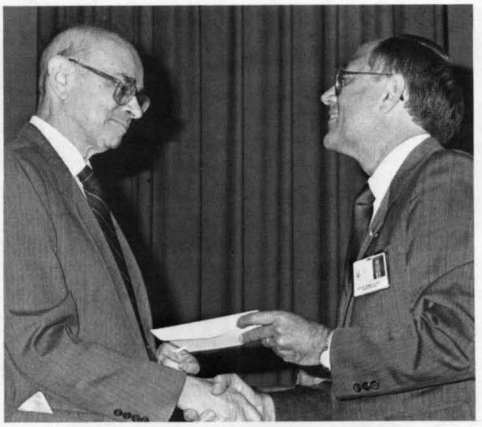
The Alumni Prize for the highest cumulative record was awarded to Mary C. Murphy-Russell.

The J. Woodrow Savacool, '38 Prize in Medical Ethics was presented to Brad A. Hinrichs, seen here being congratulated by Dr. and Mrs. Savacool.

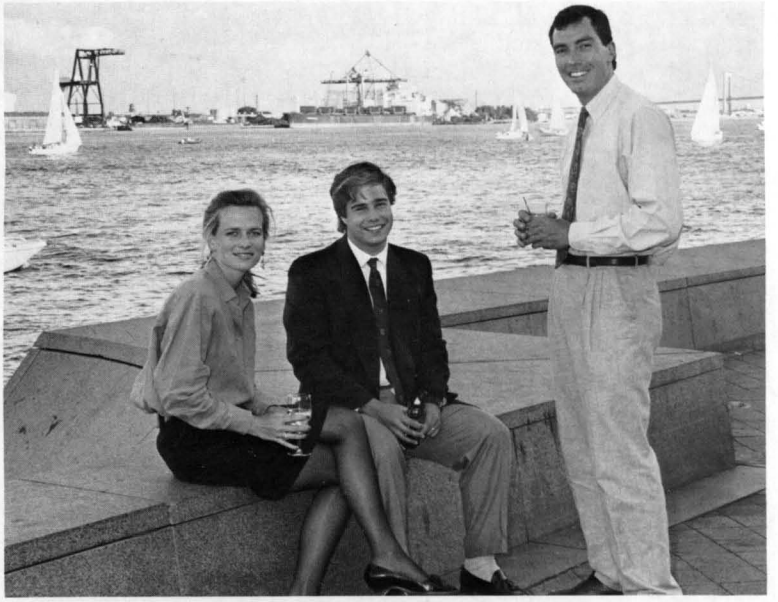
photos by
Don Walker

Geno J. Merli, '75, Clinical Associate Professor of Medicine, delivered the Class Day address.

Class Day



The Lindback Award for Distinguished Teaching in the Basic Sciences went to Edwin M. Masters, Ph.D., Associate Professor of Anatomy (left), who regrettably died eight days later (see Obituaries).



With a beautiful view from the Port of History Museum during the Senior Class Party (sponsored by the Alumni Association) are Lacey M. Chylack, Eric A. Postel, '91, and Chris G. Gussner, '91.

Varied Interests in the Class of '91

Among this year's graduates are . . . *James P. Bradley,* who while at Jefferson conducted a research project at the University of Pennsylvania on recurrent breast cancer, and was the senior author on the resulting paper . . . *Brian J. Broker,* who sails competitively and plays saxophone, keyboards, and drums professionally in both jazz and rock . . . *Walter F. Bryzgornia,* who prior to medical school taught gross anatomy and neuroanatomy at the State University of New York . . . *Margaret A. Chung,* who teaches English to Vietnamese health technology professionals at Philadelphia's Center for Literacy . . . *Mitchell I. Edelson,* who initiated the recycling programs for metal, glass, and paper for the entire Thomas Jefferson University . . . *Una M. Espenkotter,* who in college was a member of the National Championship basketball team, and at Jefferson became President of the Student Council . . . *Cynthia H. Halcin,* who as an undergraduate designed and developed an instrument still used by the Orthodontic Department at the University of Minnesota to measure growth of the mandible and maxilla by inserting titanium pins in the periosteum of the jaw . . . *Kelvin G. Lee,* who worked in an immunology laboratory while in medical school, developing blocking receptors on lymphocytes in the study of multiple sclerosis . . . *Christopher S. Levey,* who has played bass with pop star Dionne Warwick and jazz giant Buddy Rich . . . *Lisa Marcucci,* who worked for ten years as an open-hearth-furnace foreman for Bethlehem Steel, supervising a crew of fifteen steelworkers . . . *Polly J. Mirsky,* who has been a United States Figure Skating Association gold medalist in ice dancing . . . *Donald H. Perlo,* who between college and medical school coauthored *Jazz Portraits: The Lives and Music of the Jazz Masters,* a 610-page book published by William Morrow & Company, New York . . . *Louis Russo,* who for ten years danced principal and solo roles with the Scapino Ballet of the Netherlands, the Royal Ballet Theatre of London, and the Pennsylvania Ballet Theatre . . . *Samuel M. Ventrella,* who founded the University City Hospitality Coalition, which provides meals, shelter, and clothing for some of Philadelphia's homeless . . . *Anthony C. Zacchei,* who worked at Mercy Hospice in Philadelphia for homeless women and children, and as a volunteer counselor with the Ronald McDonald camp for children with cancer. □

Three generations: Sandra Wojtelwicz (Mrs. James W.) Freeman, B.S.N. '88; Mrs. Albert W. Freeman; Dr. and Mrs. William A. Freeman, '64; James W. Freeman, '91; Albert W. Freeman, '36.

Jefferson Relationships

In the Class of '91

Adler, Caleb M.	Marthe E. Adler-LaVan, '87	*sister*
Andrews, Joseph J.	Peter J. Andrews, '59	*father*
Beauchamp, Jeffrey T.	David T. Beauchamp, '59	*father*
	Eugene W. Beauchamp, '20 (deceased)	*grandfather*
	Eugene W. Beauchamp, Jr., '50	*uncle*
Bilinski, Carol A.	Raymond C. Grandon, '45	*cousin*
Brennan, John P.	John P. Brennan, '60	*father*
Britchkow, David S.	Barry Corson, '68	*father-in-law*
Brody, Marion B.	Jerome I. Brody, '52	*father*
Bryzgornia, Walter F.	William J. Peters, Jr., '70	*cousin*
Burke, M. Linda	James F. Burke, '36	*father*
	James Francis Burke, Jr., '66	*brother*
Chao, Lynn	Wen Chao, '90	*cousin*
Chmielewski, Steven	R. Robert E. Chmielewski, '59	*father*
Cook, Elizabeth F.	Jerome I. Cook, '54	*father*
Dougherty, Mary C.	John F. Giering, '31	*uncle*
Druffner, Mark R.	Charles R. Druffner, '60	*father*
Duca, Maria D.	Peter R. Duca, M.D., faculty	*father*
Fang, John Y.	Jane Y. Fang, '89	*sister*
Farrell, Michael J.	Thomas J. Allardyce, '90	*cousin*
Federici, Benigno D.	Valerio J. Federici, '48	*father*
Fitzpatrick, James T.	James J. Fitzpatrick, Jr., '52	*father*
Freeman, James W.	William A. Freeman, '64	*father*
	Albert W. Freeman, '36	*grandfather*
Friday, Jean A.	Daniel M. Friday, '63	*father*
Haag, Colette A.	Burritt L. Haag, '59	*father*
	Thomas B. Mervine, '40	*great-uncle*
Hinrichs, Brad A.	Robert A. Hinrichs, '54	*father*
Kambe, Arbetta M.	Joseph C. Kambe, '71	*brother*
Katchman, Stacy D.	Jerome J. Katchman, '60	*father*
	Steven E. Copit, '88	*cousin*
Lauricella, Roseann	John P. Lauricella, '54	*father*
Maser, Benjamin M.	Steven A. Maser, '87	*cousin*
Mirsky, Polly J.	Matthew E. Krupnick, '90	*husband*
Murphy-Russell, Mary C.	Leo J. Murphy, '35	*father*
Rosenbaum, Lawrence C.	Jerald M. Rosenbaum, '62	*father*
Sabol, Carolyn L.	John R. Sabol, '57 (deceased)	*father*
	Jennifer L. Sabol, '90	*sister*
	Peter A. Justin, '31	*grandfather*
Sanderson, Matthew C.	Vincent R. Sanderson, '64	*father*
Simons, Robert M.	Carl I. Simons, '59	*father*
Slawek, Joseph E.	Paul P. Slawek, '67	*uncle*
Sodowick, Bradford C.	Henry Gelband, '62	*uncle*
Strong, Edward B.	Carol H. Konhaus, S'44	*uncle*
Ward, Kristine M.	Maurice J. Ward, Jr., '63	*father*
	Maurice J. Ward, '29 (deceased)	*grandfather*
Whitmoyer, Stephen R.	John F. Wilson, '37	*step-grandfather*
Woratyla, Steven P.	John J. Schubert, '59	*father-in-law*
Yavorek, Vincent R.	Henry G. Yavorek, Jr., '85	*brother*
	George A. Yavorek, '87	*brother*
	Amy Yavorek, '88	*sister*

Big Turnout for a Big Weekend

The Alumni Banquet at the Ritz-Carlton Hotel on Friday, June 7 honored Achievement Award winner J. Wallace Davis, '42. Special recognition was also given to the "Great" Class of '56, which has had a particularly outstanding record in annual giving since it left Jefferson as graduates. A plaque in their honor, presented by Dr. Davis at the Banquet, now hangs in the lobby of Jefferson Alumni Hall.

Moderating the Clinic Presentations the next morning was Jack W. Fink, '54.

On Saturday evening, four classes held their reunions at the Hotel Atop the Bellevue, while the youngest classes ('81 and '86) met at the Downtown Club.

The Class of '36 had three chairmen for their reunion: Gabriel E. DeCicco, '36, Barclay M. Brandmiller, '36, and John L. Farmer, '36. Frederick B. Wagner, Jr., '41 fulfilled these duties for the Class of '41, which had a spectacular turnout.

The Philadelphia Club was the scene of the Forty-fifth, chaired by William H. Baltzell, '46. Randall M. McLaughlin, '46 read ". . . a special poem/In honor of this affair,/Dedicated to all of you,/And to this reunion that we share." The audience cheered the conclusion, "Let's do this again in another five years."

A remarkable number of classmates came to the Fortieth Reunion, with Daniel T. Erhard, '51 as chair. Holding that office for the Thirty-fifth was Leopold S. Loewenberg, '56. The party at the Rittenhouse Hotel for the Class of '61 was chaired by Stanton N. Smullens, '61.

The members of the Class of '66 wore baseball caps made for the event by Lynn M. Cranmer, wife of Lynn G. Cranmer, '66. Cochairmen of the reunion were James F. Burke, Jr., '66 and Edward T. Carden, '66. Stephen C. Silver, '71 chaired the party for his class at the Four Seasons Hotel.

Heading the big attendance at the Fifteenth was Reunion Chair Scott M. Goldman, '76. There was also a large crowd at the Tenth, chaired by Leslie S. Squires, '81. Chair for the youngest reunion was Gregory Mokrynski, '86. □

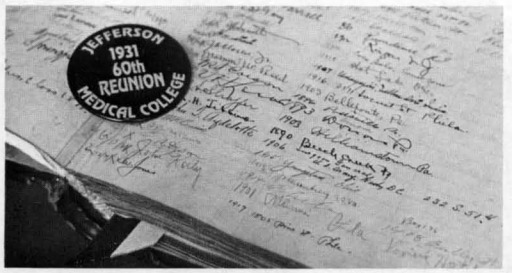
photos by Don Walker

"Managing Career and Family" was showcased at the Women's Forum on Saturday morning, June 8.

Jeffrey A. Amer, '81 and daughter on Saturday morning

Dr. Davis with Eugene F. Bonacci, '56, Class Agent for the "Great" Class of '56

Cora L. Christian, '71, Beverly C. Borlandoe, '72, and Dr. Christian's niece, Anita Wells, at the Dean's Luncheon



Speakers and audience members at the Clinic Presentations signed in the roster, as have alumni since the nineteenth century.

Jerome J. Vernick, '62, President of the Alumni Association, led the ceremonies at the Alumni Banquet.

Robert Neroni

John L. Gompertz, '36 and Bernard Mason, '36 at the Fifty-fifth

The Class of '51

photos by Robert Neroni

J. Murray Dolphin, '46 with Herbert V. Jordan, Jr., '46

photos by Don Walker

From the Class of '61: Dr. and Mrs. Elliott Perlin, Dr. and Mrs. Stanton N. Smullens, Dr. and Mrs. Robert W. Solit, and James L. Snyder

The Thirty-fifth

From the Class of '81: John S. Radomski, Stuart L. Gordon, and Dr. and Mrs. Gregory D. Slick

photos by Robert Neroni

Dr. and Mrs. Hugh B. Cummings, '86; Eugene F. May and Patricia A. Shuster, '86; Dr. and Mrs. Todd A. Morrow, '86

Reunions '91

The Class of '66

photos by Don Walker

Dr. Goldman at the Fifteenth

Robert Neroni

At the Twentieth: Drs. John F. Motley, Carolyn S. Crawford, and James J. Nocon

Many stayed for the brunch on Sunday morning.

Don Walker

1991 Alumni Achievement Award

J. Wallace Davis, M.D. '42

The alumni's highest honor was given this year to J. Wallace Davis, M.D. '42, who has chaired the Alumni Annual Giving Fund Committee since 1964, during which time $17,572,653 has been contributed to the University through this program. It is a remarkable accomplishment by any standard. Dr. Davis points to the Class Agents as the backbone of this success.

The son of Warren B. Davis, M.D. '10, the first Chief of Plastic and Reconstructive Surgery at Jefferson, J. Wallace Davis was educated at the Episcopal Academy and Dartmouth College. "He graduated from Jefferson as the winner of the Obstetrics Prize, the Gynecology Prize, the Orthopaedic Surgery Prize, and the C. V. Mosby Company Prize for Obstetrics and Gynecology," recalled Professor Emeritus of Surgery John Y. Templeton III, M.D. '41 in presenting the Achievement Award to his longtime friend at the Alumni Banquet.

Following a rotating internship here, Dr. Davis served for three years in the China/Burma/India theater of World War II as a flight surgeon and Major in the Army Air Corps. Returning to Jefferson for a residency in plastic surgery, and a preceptorship in general surgery, he went into practice in his father's old office at 135 South Eighteenth Street.

Dr. Davis was regarded as the physician's plastic surgeon by medical families in the Philadelphia area for many years. His clinical acumen and technical abilities were widely recognized, and his professional demeanor was the nidus for scores of surgical students to enter the field of plastic and reconstructive surgery. "A quiet, unassuming gentleman" is how he is described by Assistant Professor of Surgery James W. Fox IV, M.D. '70, his practice associate of many years, who adds, "He has been a role model for me in plastic surgery."

Dr. Davis retired from active clinical practice in 1988, and is now an Honorary Clinical Associate Professor of Surgery (Plastic and Reconstructive) at Jefferson. He and his wife, Gail, live in Gladwyne, Pennsylvania. They enjoy gardening and travel to such spots as Mexico, and have two grown children, Leslie and Jeff (John Wallace Davis III).

Nearly every office in the regional and national plastic surgical societies has been held by Dr. Davis, including Life Trustee and member of the Board of Directors of the American Society of Plastic and Reconstructive Surgeons, Executive Officer and Treasurer of the Society, Chairman of its Judicial Committee, and President of the Robert H. Ivy, M.D. Plastic Surgical Society. He is a longtime member of the J. Aitken Meigs Medical Association.

At Jefferson Dr. Davis has chaired the Faculty Advisory Committee, and served on the Resources Committee and the Trustee Development Committee. He was presented with the Cornerstone Award in 1978, the Winged Ox Award in 1983 (as well as receiving the Samuel D. Gross Distinguished Service Award of the Department of Surgery that same year), and the Dean's Medal in 1986. Last December, his practice associates Dr. Fox and Assistant Professor of Surgery John H. Moore, Jr., M.D. established the Davis Lecture in Plastic and Reconstructive Surgery at Jefferson. □

A Fresh Look at the Silent Gallstone

Requiem for a Celebrated Therapeutic Controversy

by J. Edward Berk, M.D. '36

What to do with the patient discovered by one means or another to have a "silent" gallstone has been the subject of sharp controversy for years. This presentation proposes to examine some of the major considerations underlying this controversy in the light of newer information and recent therapeutic developments.

Definition

A "silent" or "asymptomatic" gallstone as here discussed is a stone or stones found to be present in the gallbladder without any attendant abdominal pain of the nature of biliary colic. Dyspeptic symptoms per se (such as are commonly denoted "flatulent" or "gaseous indigestion") are given no weight as clinical expressions of gallstone disease inasmuch as there is no convincing evidence that they bear any specific relationship to cholelithiasis.

Importance of the Problem

A description of the frequency of silent gallstones and what happens to patients harboring them should help place this vexing problem in perspective and indicate why it must command respect. Such data, however, are amazingly sparse. Moreover, what data are available are hampered by various limitations and shortcomings.

Based on the limited information at hand, it may be estimated that roughly ten percent of the population of the United States have gallstones: twenty percent of women and ten percent of men fifty years of age and older. Some twenty-five million American citizens harbor gallstones and one million new cases develop each year. Within the general population are subgroups which are especially prone to gallstone disease. Particularly notable in this regard are Hispanic and American Western Indian women. The available data further suggest that some eighty to ninety percent of this large pool of gallstones are entirely asymptomatic.

Clinical Considerations

1. Earlier studies, composed in the main of necropsy observations and intraoperative findings, promulgated the impression that in as many as half the cases of silent gallstones, symptoms would ultimately develop. Furthermore, it was the general view that the initial symptomatic expression frequently took the form of a serious complication which often demanded immediate surgical intervention.

More recent observations encourage a much brighter outlook. Even though skewed by being heavily weighted with men, the studies reported by Gracie and Ransohoff (1, 2) are generally accepted as the most informative and complete of those made to date in this country.

Don Walker

Dr. Berk is Distinguished Professor of Medicine at the University of California, Irvine.

These observers followed 123 members of the faculty of the University of Michigan with silent gallstones which were detected by oral cholecystography performed during comprehensive health evaluations conducted between 1956 and 1969. Their data indicate that the cumulative probability of developing a biliary problem is roughly one percent per year. Thus, only approximately one in every four subjects with silent gallstones known to have been present for twenty-five years will likely develop biliary symptoms. Furthermore, and importantly, in some ninety-five percent of the patients in whom biliary symptoms appear, the initial clinical expression is apt to be biliary colic and not a serious complication.

2. Fear that the calculi will render the gallbladder prone to undergo malignant change has long hung as a pall over this condition and markedly influenced the therapeutic approach adopted toward it. Accumulated evidence has now made clear, however, that this fear has been exaggerated. While it is true that the stone-bearing gallbladder is more disposed to cancerous transformation, the number of such incidents among patients with cholecystolithiasis is impressively small. Indeed, the number of deaths to be anticipated if elective cholecystectomy were performed throughout the United States on every patient found to have a silent gallstone would probably far exceed the number of deaths from gallbladder cancer that this practice might prevent.

3. Another nagging concern coloring the therapeutic attitude toward silent gallstones has been the impression that associated diabetes mellitus worsens the situation and increases the severity of any complication which may develop. Contrary to this conception, diabetes has been found to impose only a modest rise in risk. It is also now appreciated that the added risk ensues not from the diabetic

state but rather from the cardiovascular, renal, and other changes associated with diabetes. An additional moderating influence is the results of a decision analysis made by Friedman and his associates (3). Their findings indicated that prophylactic cholecystectomy for silent gallstones in diabetics did not appreciably increase life expectancy or improve quality of life.

4. Evidence provided by a decision analysis conducted by Ransohoff et al. (4) gave no support to prophylactic cholecystectomy in subjects with silent gallstones. They found that the difference in survival times between prophylactic cholecystectomy and expectant management in such patients was small, with surgical management actually decreasing survival slightly.

5. Recent years have witnessed a veritable torrent of new methods of treating gallstones: chemical dissolution using bile acid preparations and cholesterol solvents; physical disintegration by various means; and laparoscopic cholecystectomy. All of these procedures, however, are still under evaluation. Should the promise they seem to hold be realized after they have been more fully assessed, they may come to be selectively applied to subjects with silent gallstones.

Conclusions

Newer observations and therapeutic developments have decidedly veered opinion in the matter of the management of the silent gallstone in the direction of conservatism. The controversy attending this subject has abated and its sharpness has been blunted. Indeed, we appear at present to be penning the notes of a composition which may well prove to be the requiem for this celebrated controversy.

References

1. Gracie WA, Ransohoff DF: The Natural History of Silent Gallstones. N Engl J Med. 1982;307:798–800.
2. Gracie WA, Morse J, Barnett DF, Ransohoff DF: The Natural History of Silent Gallstones: Extended Follow-up at the University of Michigan Screening Program. Gastroenterology. 1991;100:317.
3. Friedman LS, Roberts MS, Brett AS, Marton KI: Management of Asymptomatic Gallstones in the Diabetic Patient: A Decision Analysis. Ann Intern Med. 1988;109:913–919.
4. Ransohoff DF, Gracie WA, Wolfenson LB, Neuhauser D: Prophylactic Cholecystectomy or Expectant Management for Silent Gallstones: A Decision Analysis to Assess Survival. Ann Intern Med. 1983;99:199–204.

Clinic Presentation

After Fifty Years: "Save Some,

by Mario V. Troncelliti, M.D. '41

Fifty years ago, we graduated, the Class of '41. The speaker at our graduation was a famous surgeon from Johns Hopkins. He promised us we would help some people, there were some we wouldn't help at all, but that we should do harm to no one. That was his main point.

When we did graduate, we went off by ourselves and we had everything. We had a degree, we had all the knowledge you get in medical school, we had all the equipment you'd ever need: a stethoscope, an otoscope, and so forth. We didn't even know what a laryngoscope was. The instruments we had were all used in an office. We made our own diagnoses.

As time went on, more instruments came out, more knowledge was available, and one doctor couldn't do the job. He couldn't have all the information that was necessary. So the practice of medicine went from a single physician to multiple physicians, and unfortunately, with this the patient lost contact with his advisor (I will call his physician his advisor).

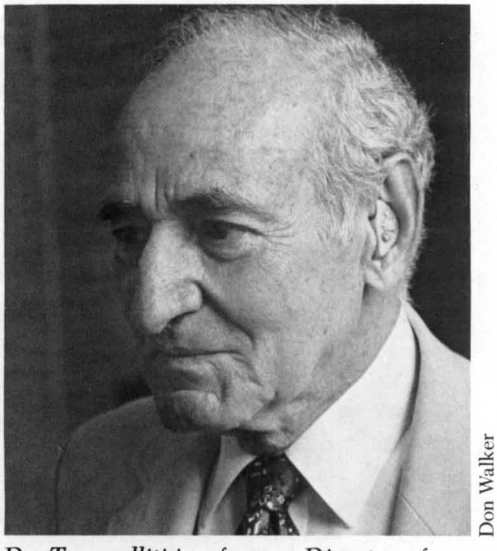
Now, when a patient goes to a hospital, or goes to a doctor's office, he soon loses contact with that doctor. He's sent to three different doctors whom he doesn't get to know at all. They tell him things he doesn't understand at all. If only he were referred back to his own doctor with the information he should have gotten from his consultants, his doctor could explain it to him, perhaps in words that they both understood.

In 1960, when the social consciousness of this country rose to a great pitch, it became a feeling that everyone who was ill, whether a millionaire or a pauper, should have equal care. This was fine when you were only using a stethoscope and your own hands. But as technology increased and the cost of medicine became so great, this became almost impossible to maintain.

As the costs rose families happened to break up, and the old people weren't cared for. They were sent to nursing homes. If you were ill, your family dumped you if they could, and you ended up as either a ward of the state or, if you were fortunate enough, you had some kind of insurance. The almighty Blue Cross and Blue Shield have been out for a while, and they did many wonderful things. They admitted you to the hospital and took care of you. There were no extra charges in those days. If you had Blue Cross, your hospital bill was probably going to be paid completely.

With advances in medicine, third-party payers were established. At first, doctors looked upon them as some kind of a plague. As it turns out, third-party payers made some physicians wealthy. If you didn't have insurance, Uncle Sam was the guy who was going to pay your bill. Pretty soon, the bills became prohibitive. A new term was established, "cost containment." That didn't mean anything except "don't pay the provider as much," or "work out a way so the provider gets less money," whether it be the hospital or doctor.

Cost containment has failed miserably. Those of us who had Medicare found that it didn't quite cover all of your medical debts, so you bought what was called a Medigap policy. When you read the Medigap policy, you find it is almost



Don Walker

Dr. Troncelliti is a former Director of the Department of Anesthesia at Pennsylvania Hospital.

Help Many, Harm None"

impossible to know what they cover. It's interesting to realize that forty percent of the cost of Medi-gap insurance goes not to the providers of medical care, but to the insurance company, the advertisers, or something else. The need for a better way of paying for medical care is here and it's going to be here for a while.

Back in that famous time of 1960 the business community was flourishing, everybody had a job, and the insurance came with your job. It seemed like a good way to have insurance when things were really humming, but the poor rascal who lost his job when things slowed down had no reasonable way of acquiring insurance, so he became a ward of the state if he went to the hospital.

This is the only industrialized country where a person who has a catastrophic illness can be made bankrupt because of what it costs him to pay for his medical care. The physician gets the brunt of the attack for this increase. That isn't fair, because the physician didn't raise his rates. What happened was that new technologies were developed. Every new instrument that came out had to be bought. People didn't want to use cautery, they wanted to use a laser. These things may be good, but they are very expensive.

The hospitals all became entrepreneurs. They were no longer charitable institutions. They were selling something. They had a burn unit, a trauma unit, and anything that would be a good means of advertising and getting more patients into their hospital. It turned out that some of these things didn't pay. A burn could be a devastating thing to a hospital, because a patient stayed too long. A trauma unit at the wrong location could have a bad financial report because of the many people who came and stayed there who could not pay. And if they had so-called Medicaid, it was nowhere near enough.

Even with our Medicaid and Medicare, there are about thirty-five million Americans uncovered by insurance. Ten million of these are children.

The matter of taking care of patients has become such a business that the federal government had to pass some legislation—the "Cobra," which says that you are not allowed to dump patients. I hadn't realized that this practice was so popular. If a patient came to the emergency ward and it looked like he was going to be a long, nonpaying patient, it became hospital policy at some institutions to send that patient elsewhere. They had to pass a law so that people would not do that.

We have insurance companies that are not paying their debts. We have people who are cheating insurance companies. We have researchers who are lying like anything. We have prestigious hospitals who are spending money on boats and lying about the research they are doing. The whole way we look at things is distorted.

In a reunion letter we were told that there are only fifty-seven of us left of the 120 who graduated. I had to attend some of these funerals, and I thought that perhaps we who remain might repeat an adaptation of the Twenty-third Psalm:

The third-party payer is my shepherd,
I shall not want;
He maketh me wealthy with generous fees,
He leadeth me through Medicare,
HMOs, and PPOs.
He restoreth my soul with promises of
breakthroughs
In cancer, AIDS, and genetics;
He guideth me through Utilization
Review, Quality Assurance,
Peer Review Organization, for hospital
Accreditation's sake.
Yea, though I walk through the valley
Of IRS investigations,
In the shadow of the penitentiary,
I fear no evil, for I have a lawyer, mal-
practice insurance,
And am a member in good standing of
the AMA;
They comfort me.
My accountant prepareth my 1040
In the presence of my secretary.
Thou annointest my income with nontax-
able bonds;
My deductions and charitable contributions
Make my cup runneth over.
Social securities and annuities shall follow me
All the days of my life,
And I shall dwell in the continuous care facility
Forever. □

Editors' Note: The following presentation offers details on a procedure mentioned above by Dr. Berk.

Clinic Presentation

Cholecystectomy via Video Laparoscopy

by Earl K. Sipes, M.D. '46

Cholelithiasis remains one of the most frequently encountered gastrointestinal problems. It is estimated that twenty million Americans have the disease. Cholecystectomy is the "gold standard" treatment procedure—some six hundred thousand are performed each year—but because of the severe pain, many days in the hospital, and long recovery periods, several alternate nonoperative approaches have been developed. These include gallstone dissolution therapy, lithotripsy, and percutaneous drainage. Success rates were not impressive, however, and recurrence of disease was common. Nothing had replaced the standard cholecystectomy (SC) until video laparoscopic cholecystectomy (VLC). Laparoscopy, literally "abdomen looker," has been a well-known gynecologic procedure in Europe for many years, but it did not become prominent in the United States until 1968. Since then it has become one of the most common procedures in the practice of gynecology because of its safety, simplicity, and the panoramic view of the pelvis it affords.

Since the first video laparoscopic cholecystectomy was performed in the United States in 1988 this procedure has been received with enthusiasm by both patients and surgeons. Approximately twenty thousand were done this year. There are definite advantages for the patient: the hospital stay may be one or two days, the pain is much less, there is easier ambulation, eating is no problem, the time of return to normal activity is shorter, and the return to work date is decreased—in some cases to as little as two weeks. The only disadvantage in doing the VLC is time, since it takes a little longer than the SC. The risks for the patient are the same for the two types of procedures.

The indications for VLC are the same as for SC. They include acute and chronic cholecystitis with cholelithiasis,

recurrent episodes of pancreatitis, symptomatic patients with polyps in the gallbladder, and acalculous cholecystitis. The contraindications are similar to those of SC with the addition of history of many previous operations, peritonitis, intestinal obstruction, and pregnancy.

The laparoscope is actually a telescope that magnifies twenty times. It is about twelve inches long and comes in two diameters of five and ten millimeters. The forward-viewing design is the most common. Rather than view directly through the end of the laparoscope, a miniature high-resolution TV camera is attached. It should have at least one chip with 480 pixels. A three-chip with 700 pixels produces the best and sharpest image, thus enhancing the view of the anatomy. High-resolution video monitors are necessary. They should have at least 480 lines for a two-chip camera and 700 lines for a three-chip camera.

A xenon light source of variable intensity is a necessity. A cord is attached to the laparoscope. A cable attaches the camera to a video recorder which in turn is attached to two video monitors. A high-low insufflator line with at least six liters of carbon dioxide per minute is necessary, and eight liters is better. It is essential that the insufflator monitor the intra-abdominal pressure, and stop the flow at a given predetermined pressure. It should indicate the rate of gas flow and record total volume used. Because of cost, the energy source at our hospital is the electrocautery and not the laser.

The basic technique of laparoscopic cholecystectomy combines traditional operative laparoscopic techniques with video observation through the laparoscope. At our hospital we use a five-member operating team consisting of the surgeon, assistant surgeon, scrub nurse, anesthesiologist, and circulating nurse.

The position of surgeon and assistant are reversed for the VLC. The surgeon now stands on the left side and the assistant stands on the right side of the patient. The video monitor for the surgeon, and the insufflator are on a rack behind the patient's right shoulder, whereas the video monitor for the assistant and scrub nurse are on a rack behind the patient's left shoulder. This latter rack also holds the xenon light source and the camera recorder.

In our first procedures of this type we had an additional person operate the camera, but this is no longer the case. This function can be accomplished by either the surgeon or the first assistant.

Before undertaking this new procedure one should be an experienced biliary tract surgeon, and have taken a special course with both inanimate and animate laboratory experience. There is a definite learning curve. The performance of this type of surgery, using long instruments which are manipulated outside the abdomen as they function inside the peritoneal cavity, while simultaneously being visualized indirectly on a video monitor, can prove to be quite a problem for the novice.

The patient receives a broad spectrum antibiotic prophylactically. The VLC is performed under general anesthesia, and a nasogastric or orogastic tube and Foley catheter are inserted. Additionally, compression boots are applied to both lower extremities to maintain venous flow. All of these procedures are terminated at the end of the operation. General endotracheal anesthesia is accomplished and all intravenous and arterial lines are inserted. Next, the abdomen is palpated while the patient is placed in Trendelenburg position. Two towel clips are used to pick up the skin and subcutaneous tissue on either side of the umbilicus, then elevated upward. A small transverse incision can be made at the supraumbilical area, or a vertical incision made through and extending above the umbilicus. Next, the Verres needle, which is about two millimeters in diameter and seven to eight centimeters long, is thrust through the fascia and peritoneum. Since the abdominal wall is thinnest at the umbilicus, the needle is directed lightly toward the pelvis. The saline drop test is then used to determine whether or not the peritoneal cavity has been entered. If the test is positive, the insufflator tubing is attached to the needle and three liters of carbon dioxide gas are pumped into the peritoneal cavity producing a pneumoperitoneum. The clips again are lifted upward, and a ten-or eleven-millimeter trocar and sheath are placed in the umbilical skin opening; with pressure and rotating motion, the trocar enters the peritoneal cavity. The trocar is removed and the sheath remains in place. The patient is taken out of Trendelenburg position and placed in reverse Trendelenburg with the left shoulder down. The video monitors are turned on, the xenon light is turned up, the camera is "whited," and the lens is wiped with a defogging cloth. The pneumoperitoneum is maintained at about fifteen liters throughout.

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Dr. Sipes, seen here with his wife and assistant, Helen, is Chairman of the Department of Surgery at Sacred Heart Hospital in Allentown, Pennsylvania.

The laparoscope is now inserted into the umbilical sheath and the lower abdomen and pelvic areas are explored. Under direct vision, a ten-millimeter trocar and sheath are inserted just below the xiphoid and to the right of the midline. This is the operating surgi-port. Next, a five-millimeter trocar and sheath are inserted at the midclavicular line two to three fingerbreadths below the costal cage, and a second five-millimeter trocar is inserted at the anterior axillary line opposite the umbilicus. A grasper is inserted through one lateral surgi-port and the dome of the gallbladder is grasped, elevated, and gently pushed over the liver and toward the right shoulder. The dissector, through the operating port, is used to take down the adhesions and fatty tissue from the gallbladder, exposing Hartman's pouch. A second grasper is inserted through the midclavicular subcostal port and is used to grasp Hartman's pouch, thus putting the ductal area on stretch. The soft tissue around the cystic duct and artery is gently teased until each one is totally free. The common duct and hepatic artery should be visualized in order to prevent injury or demonstrate any abnormal anatomy. The cystic artery and the posterior branch are triply clipped proximally and distally. The cystic duct is clipped next to its junction with the gallbladder. The artery is then transected between clips and a "flute" hole is made

in the cystic duct. A cholangiogram is accomplished by inserting a small catheter into the opening of the cystic duct. If X rays are normal, the cystic duct is doubly clipped above the common duct. The gallbladder is removed by subserosal dissection from the ductal structures up to the dome. Any oozing is controlled with electrocautery.

A twenty-French Saratoga drain is inserted through the right subcostal port and placed in the gallbladder fossa. The grasper in the right lateral port picks up the free gallbladder by the ductal structures and both are directed into the umbilical sheath; the sheath grasper and gallbladder are then removed. Should the gallbladder and stones be too large, the linea alba can be incised. The abdomen is deflated and all sheaths are removed; the fascia is closed with 0-Vicryl and skin with subcuticular 4-0 Vicryl. The Saratoga drain is attached to a fifty-millimeter wall suction unit and serves as an aid in monitoring any possible bile leak or bleeding.

The patient usually goes home within one to two days.

The following is a brief report of our experience at Sacred Heart Hospital.

From July 10, 1990 to June 7, 1991, a total of 211 VLC's were performed by four surgeons. Sixty percent of these patients had successful cholangiograms. We encountered the following complications:

- Three bile leaks were reported; all responded to simple drainage.
- There were three instances of bleeding from unligated branches of the posterior cystic artery requiring laparotomy —two immediate and one delayed.
- Five patients had to be converted to open procedures.

There were no deaths.

The length of stay varied from one day to three weeks.

The largest stone removed was four and one-half by eight centimeters.

Eight patients presented challenges in addition to cholelithiasis:

- Common duct exploration with stone removal and insertion of "T" tube: one patient
- Drainage of pancreatic pseudocyst: one patient
- Situs inversus: one patient
- Pregnancy: one patient (eight weeks)
- Inguinal hernia: four patients
- Appendectomy: one patient.

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Clinic Presentation

Algae and Disease

by Morton Schwimmer, M.D. '51

Often when I introduce the topic of algae and disease people think that I am going to talk about allergy. Considering the intensity of recent studies of disease-producing agents it is disturbing to see how little attention has been paid to the ideological role of toxic algae. This neglect undoubtedly stems from the fact that most articles dealing with algae have appeared in nonmedical publications beyond the physician's reading orbit.

Since the publication of our monograph, "The Role of Algae and Plankton in Medicine," by my brother, David Schwimmer, M.D., and myself in 1955, we have participated in several international algae seminars. In 1962 we presented a chapter, "Algae and Medicine," at the NATO Advanced Study Institute Seminar on Algae and Man, at the University of Louisville in Kentucky. In 1967, we presented a chapter, "Medical Aspects of Phicology," at the seminar Algae, Man, and the Environment, at Syracuse University. Since that time many additional reports have emphasized the toxic potential of algae.

Algae are amongst the simplest forms of plant life. Most are aquatic with either freshwater or marine habitat, although they may exist on land, or in the air. There are over twenty thousand known species. Of these, less than one hundred presently have medical significance.

We are interested in the actual intoxications in animals and man resulting from ingestion, inhalation, or contact with noxious algae and their by-products. In 1836, Valentin first reported the isolation of algae in the normal animal alimentary tract. Though it has been standard procedure among algologists to credit Francis's report in *Nature* in 1878 as being the first to recognize algol toxicity, actually a physician, a Dr. Farr, reported in 1842 to the Microscopical Society in London on algae causing a gastrointestinal disorder in a young female. He opined that it might have come from the city drinking water. Since 1878 hundreds of episodes of fresh water algol toxicity have been reported in the literature.

The parameters favorable for profuse algol growth and the development of toxicity include: water; warm weather; ample phosphates, nitrates, and other nutrients; and upwelling water or winds blowing towards the shore.

The clinical picture of algol intoxications in animals has been remarkably diverse. Although no system has been

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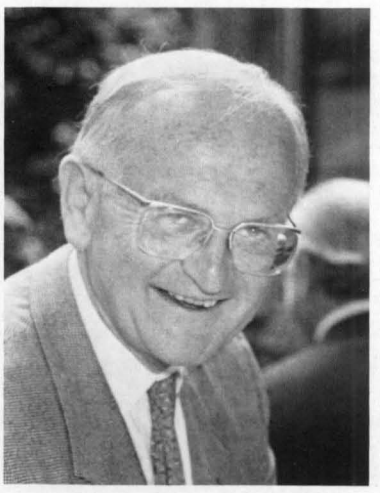


Don Walker

immune, symptomatology has been chiefly digestive, neuromuscular, respiratory, and cardiovascular. Renal and dermatologic involvement have been less prominent. The sequelae of algol poisonings, acute or chronic, have in the main been unrecognized, since veterinarians, like physicians, possess little awareness of algol noxiousness.

The clinical and autopsy findings following experimental administration of uni-algol cultures parallel those seen on administration of naturally occurring toxic blumes. Fish, like land animals and birds, have also been victims of algol poisonings. As might be expected, fish deaths have been reported only when occurring en masse. They have been noted in all types of water: fresh, brackish, and marine. It is frustrating to note that fish kills are routinely attributed to diverse causes such as: changes in water temperature; oxygen lack from blocking of gills by sand, or from blanketing of the water surface by algae; botulism; contamination of the water by insecticides or industrial pollutants; and even detonation of underwater mines. The role of algol toxins has been generally more unknown than discounted.

The fish exposed to toxic algae appear to have breathing difficulties and spacial disorientation. Again experimental administration of uni-algol cultures, freshwater, brackish, and marine, duplicate the clinical picture. We know that algae are present in air, water, and soil, on plants, animals, and various food products. We also know that algae can enter the human body by inhalation, ingestion, injection, and contact. One may breathe them just into the nose, or all the way down into the bronchi and alveoli. As with animals, human respiratory exposure to toxic algae can lead to dyspnea, wheezing, choking, cyanosis, and even foamy nasal discharge.

Following ingestion of toxic algae the most common symptoms are stomach cramps, nausea, vomiting, diarrhea, headache, and fever. Human skin disorders include those of direct irritation and those due to allergenicity. Fishermen and swimmers have complained that the red tide burned their arms and hands. Contact with certain blue-green algae in lakes can give skin eruptions and conjunctivitis. Indirect effects of algol toxins can be noted in paralytic shell fish poisoning and in icthyosarcotoxicosis.

There are many areas for further speculation and investigation. We know that various blue-green algol toxins have the ability to cause hepatitis, jaundice, and cirrhosis. We also know that algae are omnipresent in vineyards, wineries, and many fermentation processes. Some patients who drink too much alcohol develop cirrhosis. This merits further examination.

Many of the toxic algae have been shown experimentally to produce extensive neurologic symptoms and pathologic findings. What about the various neurologic disorders for which we have as yet no identified cause, or cardiac manifestations following exposure to toxic algae vis-à-vis myopathies and other cardiac disorders?

In forensic medicine the presence of diatoms in various organs of the human body such as the spleen, liver, kidneys, lungs, and bones has been used as a criterion for the diagnosis of death by drowning. We are entitled to wonder about their presence by other means of bodily entry, with possible adverse affects such as stone formation. Injection and ingestion of algol derivatives have frequently caused elevation of blood sugar. What role this might play in diabetes is speculative. Injection of algae and feeding of algol cultures have at times caused cataracts. Certain blue-green algae found in the mouths of humans and animals have the ability to dissolve cement in dams. Certain other algae have the ability to bore holes in the teeth of fish. What role this may play in dental caries remains to be elucidated.

There are at least a half dozen reports of injection or contact with algol derivatives producing tumors in experimental animals. I might add that to the best of my knowledge there are no drinking water standards for toxic algae in the water supply in this country or elsewhere.

I have just touched briefly on the toxic effects of algae in humans. Because of the low index of suspicion by physicians who are unaware of algae, let alone algol toxicity, the number of diagnosed algol illnesses has been pitifully small. I think it is important for us to consider algol toxicity in certain diseases for which no ideologies have yet been established, or for which other ideologies may have been assumed with insufficient proof. If you don't look for it, you won't find it. □

Clinic Presentation

Medical Decision Making

by Pierre L. LeRoy, M.D. '56

The process of decision making evolves in five steps: definition of the problem, search for alternatives, selection, implementation, and outcome, or response to commitment.

Let's look at the evolution of decision making. Professions have been defined as occupations that have established jurisdiction over certain kinds of services and negotiated considerable freedom from external intervention and control over their work. This carries the caveat that we have autonomy, but we must monitor ourselves. Have we done this effectively?

At the time we graduated from medical school we were filled with new enthusiasm for clinically managing diagnosis, treatment plans, and continuity of care.

Following graduation, clinical decision making was personal, primarily limited to selecting practice location, licensing, and choosing a residency.

This was before Medicare, in 1965, federally centralized our medical practice decision making, while creating a new type of clinical physician specialty: the "Part B Medical Provider." In developing medical administrative specialists Medicare created a paradigmatic shift in clinical practice and decision making.

Medical publications in the Surgeon General's office have grown from a four-foot shelf in 1865 to over four million items now in custody at the National Medical Library. This includes some twenty-one thousand journals as well as twenty different Medlar indexes.

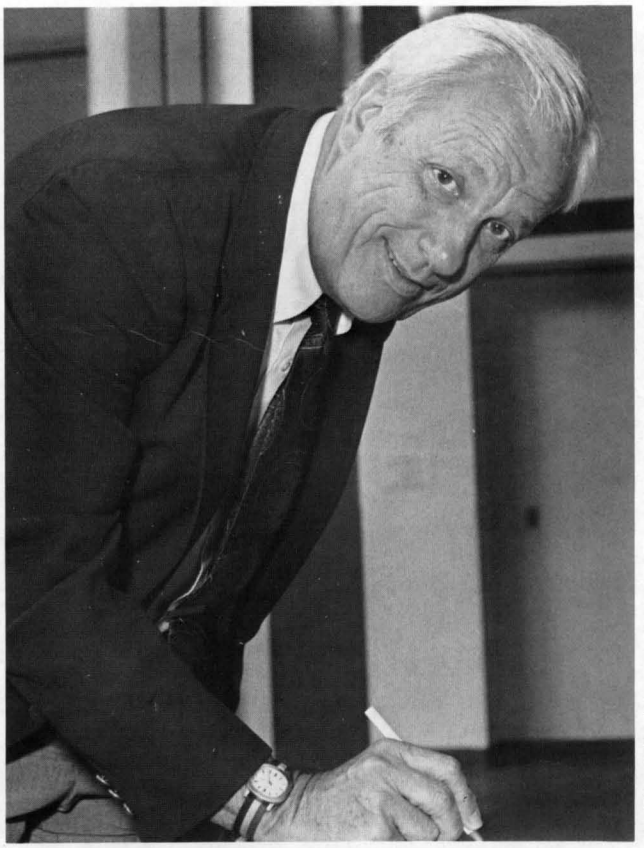
New biotechnology incorporating socioeconomic changes has also evolved, modifying clinical trends. Mandatory documentation created by a massive medical "bureauology" now in place has caused unprecedented additional strain on our health delivery system. We are forced to reconsider our decision making process and examine its two principle components: clinical and administrative. Let us focus on the new administrative concerns of health care.

The medical profession is primarily composed of physicians who are

personally responsible for patient care around the clock. The clinician has a constant, unique form of decision making to perform. Clinicians treat patients from a prospective point of view and not retrospectively. Treating patients has become more difficult because the clinician of the nineties must consider a broader scope of care ranging from molecules to mankind.

Physicians must modify their decision making process from both a prospective and retrospective point of view, since increased regulatory affairs are creating significant adversity. Let us look at the evolution of some regulatory affairs and how they have affected the medical profession.

As you know, the physician responsible for patient care is required by law to diagnose and treat medical conditions affecting the patient. Patient care is the primary responsibility of the treating physician, and the clinician is the patient's advocate, but decision making is no longer limited to just making a clinical diagnosis and implementing a prospective treatment plan. On one hand, failure to diagnose and treat has become the subject of stringent malpractice sanctions, a process that was virtually nonexistent in 1956, and on the other hand the clinician is subject to a retrospective review of his or her clinical decisions by parties not accountable for patient care.



Don Walker

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During this evolutionary period, reimbursement has also drastically changed from the three-tiered system of private pay, insurance pay, and the uninsured to the nine-tiered unintegrated reimbursement system:
1) Medicare Champus (federal)
2) Medicaid (state and federal)
3) managed care (HMOs or preferred-provider organizations)
4) personal injury carriers (two thousand national; two hundred local)
5) private plans
6) employee group plans (Blue Cross/Blue Shield)
7) workman's compensation (commission or noncommission)
8) private pay
9) uninsured.
Each category has its own policies. One of the main tactics employed by the review organizations is the "reasonable and necessary" concept, which itself has not yet been subject to a uniform definition.

Managed care programs conduct a remote retrospective review of the clinician's diagnosis and treatment to determine reimbursement based on their own cost containment policies, but they have no clinical accountability before the law. This further complicates our reimbursement and administrative decision making and adds to the growing adversity problem. These reviews are now pitting physician against physician in a house divided. Some peer review organizations have even gone so far as to charge the physician for the right to appeal the reviewers' denial decision, further abusing the peer review process.

We need, therefore, to propose a set of humanitarian national guidelines to assist in our current medical decision making process—a patient's "bill of rights," if you will.

Let us consider the following "reasonable and necessary" guidelines:
1) Diagnosis is consistent with the history, physical examination, and laboratory tests.
2) Treatment is consistent with the diagnosis.
3) Laboratory tests have a rational basis and are consistent with the diagnosis.
4) Diagnostic tests and treatment are not experimental or investigative.
5) Follow-up visits are timely and relevant to the individual patient's needs.
6) Consultations with the family physician and with other medical specialists are performed on an as needed basis for further diagnosis, and treatment recommendations are subject to change with the course of the injury or disease process.
7) The patient voluntarily participates and cooperates.
8) The opinions expressed by the physician are based on the reliability and credibility of the patient's history, physical findings, and pertinent records, which are reviewed.
9) The utilization is individualized with each patient, and not based solely on generic economic criteria.
10) Diagnosis, treatment, and management are performed in the best interests of the patient's changing needs.
11) Physician reviewers must be board certified in "like specialty" and be held personally and professionally accountable for their decisions, since they become part of the health care decision making process.
12) The humanitarian aspects of the patient's medical needs are considered as far as possible, in keeping with state-of-the-art clinical medicine, while maintaining cost containment considerations.

The courts also have an important role:

witness the decision of the California Court of Appeals as reported in the Fall 1987 issue of *Malpractice Digest*. "While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgement."

Today, unfortunately, economic factors are outweighing humanitarian considerations. Doctors and hospitals must support an army of clerical personnel to determine what should be documented and paid by various insurers, each with their different rules, causing delay and denials, and further shifting the "care dollar" to an administrative dollar.

How does the physician cope with these changes? We must develop a personal model for decision making prioritized to the type of practice but divided into three interdependent categories. The first, the clinical considerations, leads to changes in the educational curriculum. These outcomes are further modified by the administrative and institutional concerns, but also serve as the basis for what is prioritized for clinical research. The second, regulatory affairs, structures clinical courses of action to be interpreted by the court functions and decisions pertaining to health care at both state and federal levels. This is further modified by fiscal reimbursment considerations which include denials, delays, and dumping from one economic tier to another—for example, workman's compensation to the Medicare budget, a practice in some industries. The third consideration is the personal, which integrates all of the above, shaping and changing the attitudes and behavioral responses of the clinician. This model can be modified to help the clinician organize and manage the decision making process.

Medical institutions must collaborate in developing both short and long range philosophical approaches to an integrated health policy to improve interprofessional communication, and to reduce costly administrative inefficiencies.

I propose the following guidelines:
1) To rededicate ourselves to prolonging the quality of useful life; to assume a fiduciary responsibility for the medical welfare of others even at personal expense.
2) To promote closer relations with our colleagues in clinical pharmacology, medicine, surgery, and psychiatry in order better to understand biology at the cellular and molecular level, which is mandatory to understanding disease processes.
3) To repel deleterious economic encroachment affecting the patient.
4) To monitor ourselves regarding utilization as well as cost containment in diagnosis, treatment, and laboratory testing.
5) To develop a two-tier integrated health care system providing both basic medical needs and a private medical plan.
6) To "adopt" a medical student, offering counseling on an individual level and guidance in decision making.
7) To encourage alumni to take an active role in health planning, as an adjunct faculty supporting the current medical curriculum in close collaboration with the faculty, administration, and trustees.

We must consider an alumni plan for clinical decision making for the second millennium that will take a leadership position in health care planning both regionally and nationally.

Unfortunately, this decade has created a schizophrenic "best for less" dilemma. We must continue to search for a sound and progressive decision making process. One humorous skeptic stated, "When all else fails, lower your standards." We have not and must not do this! Rejoice in the fact that medical progress is astounding. We have come a long way since chewing on willow bark for pain over two millennia ago, but also remember it took about 1900 years to isolate acetyl salicylic acid (aspirin) by Bayer and only in the 1950s did we begin to learn how some of it works.

Health, by any consideration, is our most priceless possession. We must, with singleness of purpose, improve ongoing medical programs, such as educating physicians for academic leadership using existing regional resources in medical education, industry, and the university, while expanding the partnership to responsible government as well.

Let us commit ourselves to a new and flexible decision making process where clinical and administrative concerns are integrated, with the best interests of the patient as the primary goal. The clinician is the head of this team!

Finally, when you are faced with a decision, make that decision as wisely as possible—then forget it. The moment of absolute certainty never arrives. □

Clinic Presentation

Jewish Medical

by Elliot Perlin, M.D. '61

Recently I have become interested in geriatrics. Being Jewish, I have looked toward Judaic medical ethics to help me in caring for some of my elderly patients, and I hope that others may find some of this information useful as well.

Judaism is a very person-oriented religion. Our lives are given by God, and taken by God. Jewish law (in Hebrew, halakah) is based on the Hebrew Bible, the Talmud, including the Mishnah, and commentaries and interpretations by scholars such as Hillel, Karo, and one of my favorites, Maimonides. More recently ethicists such as Rabbi Immanuel Jakobovitz, Rabbi J. David Bleich, and Dr. Fred Rosner have applied Judaic religious philosophy to present-day medical problems.

The attitude of Judaism toward health maintenance is very specific. It involves responsibilities for the patient and responsibilities for the doctor. With respect to the patient, maintaining good health is a religious duty. This was prescribed by Hillel. One must live in a city where a physician resides. This is prescribed by the Talmud. Restoration of health is ordained by God, and the command is found in the Bible. These rules apply throughout one's entire life.

What is the attitude of Judaism with respect to the physician? There is a lot of controversy, but it is generally agreed that God authorized the physician to heal. There are many references to this in the Bible—one in particular: ". . . and he, he shall heal." Moreover, the physician is obligated to heal. This is prescribed by the maxim "Neither shalt thou stand idly by the blood of thy neighbor" (Leviticus 19:16).

What is the Jewish attitude towards the elderly? There are many references, but I've chosen a few here. "Thou shalt rise up before the hoary head and honor the face of the old man," found in Leviticus. "Honor thy father and thy mother," of course a reference to our parents, but it could be extended to consider the elderly as well. ". . . that thy days may be long upon the land which the LORD thy God giveth thee"(Exodus 20:12). "Ye shall stand in awe of thy mother and father" (Leviticus 19:3).

Maimonides said: "How far must one go to honor one's father and mother? Even

Ethics and the Care of the Elderly

if they took his wallet full of gold pieces and threw it into the sea before his very eyes, he must not shame them. . . . Even if he is dressed in precious clothes and is sitting in an honored place before many people, and his parents come and tear his clothes, hitting him in the head and spitting in his face, he may not shame them."

This was a great physician, and he also of course was a great rabbi and scholar. He studied many aspects of medicine, and for the time in which he lived, the twelfth century, it was remarkable how much he knew. These are some of the maxims that he prescribed in his aphorisms for the elderly: "One should strive that a weak, elderly person consume some food three times daily, because a weakened body should be nourished in small amounts, at frequent intervals. Prior to any food or beverage consumption, it is proper to give elderly people something that softens their stool, be it sweet wine or softening vegetables, which are taken with oil and fish soup. Elderly people require that their bodies move, because the constitution of their bodies needs warmth." I think you can see that all of these apply today as well.

What is the doctor/elderly patient relationship? It is not really that much different from any other doctor/patient relationship. It's based on beneficence, the basic principles of ethics, respect, fidelity, justice, and humanness, even if the elderly patient is incapable, as many of them are, of interacting with the doctor. At times, of course, you may have to interact with the family as the proxy for the patient.

The Judaic interpretation is that if any human being saves a single soul, it is as if he has saved an entire world. In other words we are obligated to treat the individual. Maimonides said, "May I never see in my patients anything but a fellow creature in pain."

There is one aspect of the care of the elderly that I think is of particular importance to you and to me: the end of life. When serious illness threatens life, the physician must not abandon the patient. "He shall continue to heal." During this period the physician is obligated to try to prolong life, even though the suffering is great.

This is a principle that Judaism emphasizes more strongly than many philosophies do. We are not to say what the quality of life is—that is God's determination. Even if a patient is suffering, that does not mean we should shorten the patient's life. Active euthanasia is not permitted. The elderly patient must also resolve to want to live as long as possible. Suicide is not permitted.

Tennyson said it this way: "We are not now that strength which in old days moved earth and heaven. That which we are, we are. One equal temper of heroic hearts made weak by time and fate, but strong in will to strive, to seek, to find, and not to yield."

The physician may withhold treatment which is not likely to prolong life, when death is imminent. This is permissible when nothing that you can do will change the course of the illness. Respect for the elderly person and the soul continues during this period, and after the person dies we say Kaddish for the person, showing that we have respect for that individual even after death. One may not hasten the dying process, however—not even a little bit. A person who is in the dying state must be left alone to go through that process, because closing the eyes of the dying person might be similar to putting out that little flickering flame.

I've tried to summarize this in a little poetry that I've put together recently:

Do Not Resuscitate

She held her mother's hand
And listened to the radio
Play "Country Roads." Their
Faded photo on the nightstand
Was still pleasant to look at.

Red, yellow, black. The
Bedsores came in various colors,
Shapes, sizes. Decaying flesh. And
The severed legs. Their remnants
Quivered when she was turned.

The feeding tube mocked death,
Leading into her stomach white
Liquid, and she mixed it
With a bit of gruel.
(She would only eat for her.)

She used to ask about
The grandchildren. Now even
The glimmer in her eyes
Was gone. And locked in her
Bed, so was the struggle.

"Prolong living, not dying,"
She knew full well;
But she longed for
A sign: Where was the
Dividing line?

"Every drop of life is
Precious," her father
Had said. "Savor every
Moment of it." And she
Remembered his smile.

She kissed her mother,
Released her hand,
Smoothed the fine hair,
And thought, wistfully,
"The end of life is also life." □

Poem reproduced, with permission, from Ann Intern Med. 1990;112:152.

Don Walker

Dr. Perlin (seen here with his wife, Carole Sue, and their son, Daniel, of Jefferson's Class of '93) is an Associate Professor of Medicine at Howard University.

Clinic Presentation

Who Heals the Healers?

Progress in Monitoring and Treating Impaired Physicians

by Edward T. Carden, M.D. '66

I'd like to discuss the historical development of what is called the Physicians' Health Movement. "Who heals the healers?" is a question that is not asked often enough in the health industry. Only the finance industry spends less money than the health industry on the problem of impairment in their workers.

Originally this movement had a strong emphasis on casualties where the impairment involved dependence on drugs or alcohol, or some psychiatric morbidity. It has expanded radically since then. In June a conference on physicians' health was held in Toronto, and the American Medical Association is test-marketing a plan to indemnify physicians who test positive for HIV antibodies, so that they will get a half million dollars immediately if they are willing to withdraw from practice. This is going to shift our physicians' health movement out of low gear. Most of you, no matter where you're from, will be seeing more about this kind of activity in the future.

It all began back in 1969. The Vietnam War was going on and people were losing trust in the establishment at an unprecedented rate. Florida was the first state to pass a law called the "sick doctors act," where the diagnosis of drug or alcohol dependence was presumptive of the fact that action could be taken against a physician's license without waiting for some kind of mishap to occur. There was also a lot of activity at that time in Arizona, Connecticut, and several other states.

Texas, in 1971, followed with a similar "sick doctors act." People began to press the AMA to assume a leadership role on this problem which they realized was not being adequately addressed. Oregon referred a resolution to the House of Delegates, and eventually the Council on Mental Health issued a report which was endorsed by the interim meeting in 1972, and then published in the *Journal of the American Medical Association* in February 1973.

The expectation had been that ninety percent of impaired physicians suffered from chemical impairment. That proved to be inaccurate. Approximately one-third of impaired physicians had drug dependence as their primary problem. Another third had alcohol as their problem. Twenty-two percent had psychiatric morbidity, three percent senility, and the rest a scattering of physical disabilities and personality disorders.

Members of the AMA at that time were very careful about what they said and what they did. They spent a lot of time running away from any possibility of being interviewed by "Sixty Minutes." They were afraid that an admission of possible impairment would cause the public to lose confidence in medical professionals. They spent a lot of time going over what they should and should not say.

This, of course, was taken care of quite nicely by the Marcus brothers in New York, a famous case of obstetrician/gynecologist twins who left a scenario of unbelievable morbidity from drug dependence in all the major teaching hospitals in New York City. It went on for years. They would go from one hospital to another. The story was eventually written up as a book called *The Twins*, and a movie called *Dead Ringers*.

Don Walker

Dr. Carden is an Assistant Clinical Professor of Otolaryngology at Case Western Reserve Medical School in Cleveland, and a member of the American Medical Association's Advisory Committee on Impaired Physicians.

This notoriety really brought the heat on organized medicine to do something about the problem. New York had a physicians' committee at that time, but in 1978 a "snitch law" was passed there that essentially made any kind of anonymity impossible. It totally voided out the physicians' effort.

In 1973 G. Douglas Talbott, M.D. moved to Georgia and set up a program solely for chemically impaired physicians, run out of a treatment center. He essentially directed his efforts toward attracting cases for treatment. He did have some very good ideas such as mirror imaging, which is quite appropriate for late-stage problems. In such programs clients, before their treatment is over, go out and themselves treat people in drug treatment centers. Dr. Talbott's program has had a relatively controversial history, however, because of the conflict of interest involved when you are treating and monitoring at the same time.

California, in 1980, established the "Diversion" program primarily because they realized how expensive it is to proceed against impaired physicians through the legal system. It takes so long that someone could be out there practicing for five years before there is any definitive resolution of the problem. The "Diversion" program was set up very well, but it doesn't attract a lot of casualties because it is run by the state Board of Medical Quality Assurance. How many of you would want to refer one of your sick colleagues to the board?

In 1982, New Jersey became the first medical society and, as far as I know, the first professional organization in the world to hire a physician full-time to devote his activities to the detection, intervention, and referral for treatment, of sick physicians. Almost five percent of all physicians in the state are now participating in this program.

Florida, after passing the "sick doctors act" in 1969, laid low. In 1978, the *Miami Herald* had a big exposé of "drunken doctors." The state passed some new legislation forming a Department of Professional Regulation. They had about a six-year history of fighting over whether the board or the medical society should run the program. Eventually they came to terms, in 1985, with a group that is sponsored by the medical society, run by the medical society, but essentially paid for by the board.

The expectation had been that ninety percent of impaired physicians suffered from chemical impairment. That proved to be inaccurate.

The agreement was that they would treat not just physicians, but also dentists, podiatrists—everybody but nurses. They have fourteen groups in the program right now. The responsiveness of the system to this approach is incredible; the numbers are astronomical. The program pedaled along for years when the board was running it; then it just took off vertically.

The AMA's leadership role, though intermittent, has been critical. They proposed model legislation for states to follow in 1974, and then revisions in 1982, because this is a very difficult problem to deal with and a lot of people need expertise in getting things started. In 1984 they formed the Advisory Committee on Impaired Physicians, of which I am a member. The committee ran several national conferences, and has done whatever else it could to help the movement. Now the AMA is taking a leadership role on the HIV matter.

Johns Hopkins became the first hospital to have an employee assistance program in 1977. In 1990 they implemented a program for body fluid monitoring for recredentialing. They recredential half of their staff every year. As part of the process you are notified when to drop off a little urine, and if you don't do this you get a call from the administration. After approximately five hundred subjects, a positive urine has yet to be turned in. The reason is that they have a lot of loopholes in their system and anyone who is smart enough to work at Johns Hopkins is smart enough not to get detected.

Nevertheless, that urine matter has brought impairment into the public consciousness. People like me have been begging, borrowing, and stealing to get programs started for years and have had what I would call modest success, at best, whereas at Hopkins the issue has been put on the front burner.

There are now physicians' health programs in nine states with full-time medical directors. Eleven states have such programs with part-time medical directors. Another four states have ones with full-time employees who are not physicians. This kind of progress has resulted in the National Federation of State Physicians' Health Programs, incorporated on December 26, 1990. This federation will probably change to absorb more hospital activities; the state of California has passed legislation that a hospital cannot be licensed if it does not have a medical staff committee devoted to the impairment problem.

A central question now is "who decides what?" If physicians don't take the initiative, others outside the profession may pass arbitrary rules restricting physicians' behavior, with severe sanctions including preventing them from ever practicing again. □

Clinic Presentation

Developments in Endocrinology Over the Past Twenty Years

by Edward B. Ruby, M.D. '71

My objective is to review briefly some of the clinically important changes in the field of endocrinology that have occurred since my class graduated, with special emphasis on diabetes mellitus.

Initially I'd like to share a case with you that I saw about fifteen years ago: that of a thirty-one-year-old female who was referred in 1976 for management of her diabetes mellitus. She was two months pregnant and had been married for nine years. She had had one prior pregnancy four years earlier but had had a spontaneous abortion after two months of gestation. She was diabetic and had been diabetic for fifteen years.

Her therapy prior to pregnancy had included twenty-six units of isophane insulin suspension (NPH insulin) in the morning and eight units of NPH in the evening. She avoided sugars in her diet and would occasionally check a urine sugar to monitor her diabetes. Her other past history was unremarkable and her physical exam was only notable for scattered dot hemorrhages in her retinae. Her laboratory studies at that time were unremarkable in terms of her complete blood count, her urinalysis, and her renal function.

The patient was obviously very concerned about maintaining her pregnancy, especially since this was only her second pregnancy after attempting conception for eight years. Her diabetic management at that time consisted of outpatient visits every three weeks for the first trimester, every two weeks for the second trimester, and planned for every week for the last trimester. She was on an 1800- to 2200-calorie diabetic diet and was faithful in monitoring her urine sugars, four times a day. Also, on the days of her outpatient visits, she had lab tests for blood sugars three times a day.

Throughout the pregnancy she required gradually increasing doses of insulin, up to a total dose of twenty NPH and ten units of regular in the morning, with eight units of NPH and eight units of regular in the evening.

During her outpatient follow-up her urine sugars were usually negative to one-plus, and blood sugars 120 to 210. She was very happy at how well she was doing from an obstetrical and diabetic

standpoint, especially in comparison to her previous pregnancy. Then suddenly, at her thirty-second week, she had a spontaneous abortion.

The fetus was noted to have multiple anomalies and at her subsequent visit she vowed never to attempt any further pregnancies.

This case illustrates one of the frustrating problems that we encountered in those days in the management of diabetics, in whom glucose control is critical. Despite all of the best efforts on the part of the physician and on the part of the patient, five to ten years after our graduation there was really no good way to assess the quality of glucose control.

The importance of glucose control is indicated by the fact that tight glucose control in a diabetic mother has definitely been shown to decrease fetal anomalies and neonatal hypoglycemia. Some of the fetal anomalies occur very early after conception; therefore tight glucose control should be achieved one to two months prior to conception. Tight glucose control in the nonpregnant patient probably decreases the occurrence of chronic diabetes-related complications such as retinopathy, neuropathy, and nephropathy. This has been shown in many retrospective studies, in many prospective animal studies, and more recently in human studies. For example, there has even been a case report of regression of lesions in diabetic kidneys transplanted into a nondiabetic patient.

Improvement in glucose monitoring should assist us in improving glucose control, and thus may lead to a decrease in those complications related to chronic hyperglycemia. In 1971 glucose monitoring was, as already alluded to, via urine sugars, and good control at that time was considered anything that was negative to one-plus glucosuria.

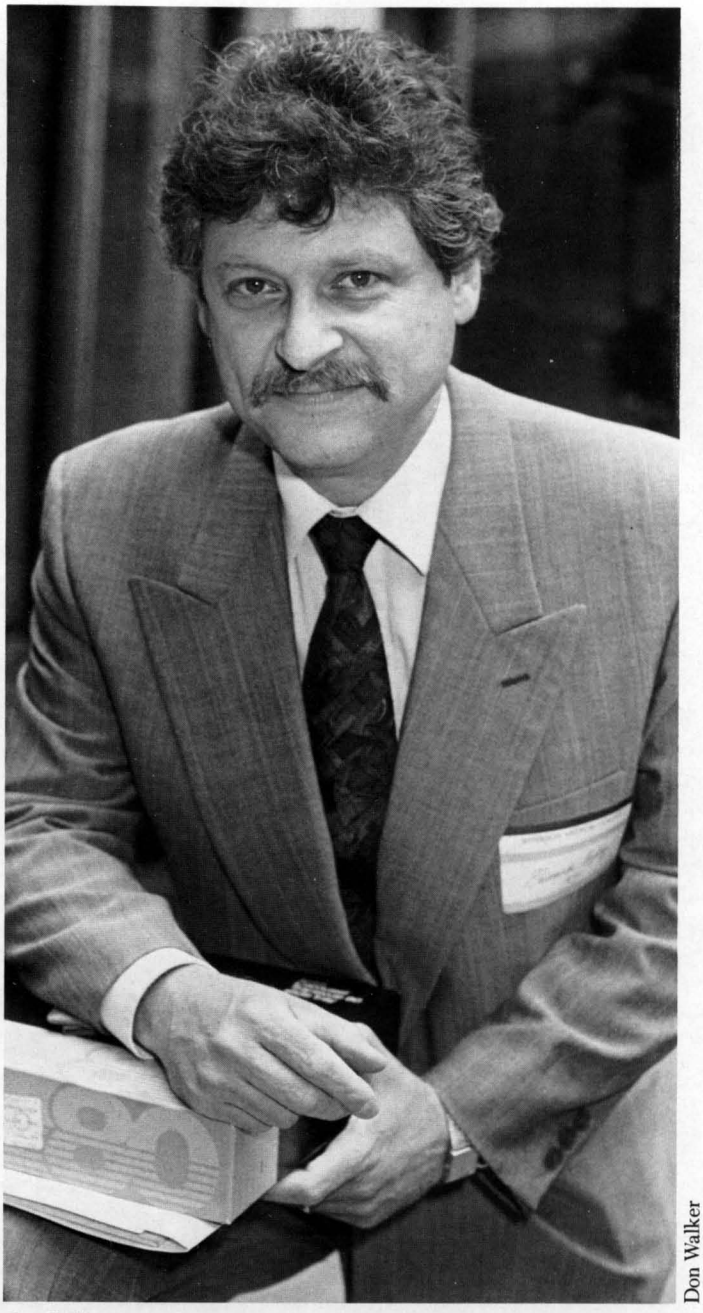
We know that the renal threshold for glucose is about 180 mg/dl in young adults and that this increases with age. Thus negative glucosuria does not necessarily equal good blood glucose control. We now have home blood glucose monitoring devices to assist us with our patient management. This has been one of the major changes in the clinical practice of endocrinology over the past twenty years.

With the monitors we place a single drop of blood on a coated strip which elicits color changes in the strip. The change can be read visually or with a computerized monitor. It's a safe, simple, and reliable procedure when it's properly done.

Good glucose control in the pregnant diabetic is about 65 to 130 mg/dl; otherwise 80 to 160 is considered good control. We also have available now, as you know, glycosylated hemoglobin, or hemoglobin A-1-C. This is based on the fact that glucose binds irreversibly to hemoglobin, and the higher the average glucose level the greater the percentage of glycosylated hemoglobin. Because of the 120-day life span of red cells, a glycohemoglobin will generally give us a two- to three-month overview of glucose control. This is used as an adjunct to home glucose monitoring.

Other highlights in the field of endocrinology over the past twenty years include advances in diagnostic techniques and advances in therapies.

Some of the advances in diagnostic techniques include the development and improvement of radioimmunoassays. We now are able to measure calcitonin,



Don Walker

Dr. Ruby is an Assistant Professor of Medicine at Jefferson, and Director of Endocrinology and Metabolism at Mercy Catholic Medical Center of Southeastern Pennsylvania.

which helps us in diagnosing medullary carcinoma of the thyroid. Our parathyroid hormone assays are much improved these days, so that the diagnosis of primary hyperthyroidism can be made much more easily than when we graduated from medical school. We are now able to diagnose prolactin-secreting pituitary tumors, and we also have assays for both twenty-five hydroxy and 125 dihydroxy vitamin D.

It's hard now to imagine medicine without some of the newer radiologic procedures. CAT scanning has developed since we graduated. This is used extensively in evaluating patients with adrenal disorders, adrenal tumors, and pituitary tumors. Magnetic resonance imaging has helped us greatly in evaluating patients with pituitary microadenomas. Ultrasound has advanced tremendously as well, and assists us in evaluating patients with thyroid nodules and ovarian tumors, and is even used intraoperatively to localize insulinomas. Bone densitometry has gone a long way in helping us to evaluate patients with metabolic bone diseases, especially osteoporosis. We have some very fancy invasive radiologic procedures that help us to localize parathyroid adenoma, especially after prior surgical failure. Also, there are invasive procedures that help us to localize ACTH-secreting pituitary microadenomas, and this has improved the neurosurgical success rate for removing these tumors from about fifty percent to a little over ninety percent.

We have developed a technique of thyroid aspiration which helps us evaluate patients with "cold" nodules. It's a very accurate procedure for nodules that are less than about three centimeters, with only about a five- to ten-percent false negative rate for cancer, and a one- to two-percent false positive rate for cancer. This obviously assists us in determining the management of patients with thyroid nodules.

Advances in therapy include the development of bromocriptine, used to treat patients with hyperprolactinemia; and the use of calcitonin as an agent to treat hypercalcemia, Paget's disease, and osteoporosis, through its interference with osteoclast cells. Arginine vasopressin is here, assisting us in treating patients with diabetes insipidus through nasal insufflation, rather than the injections that previously had to be used.

Gonadotropin-releasing hormone analogs which decrease sex steroid hormone synthesis are helpful as adjuncts in treating patients with prostate carcinoma, endometriosis, and fibroid tumors of the uterus. Somatostatin analogs decrease serotonin secretion in carcinoid tumors, and help us also in some patients with acromegaly. Of course we are all aware of the advent of synthetic human insulin, which assures us of a continuing supply of insulin, something that might otherwise have been in doubt.

We now have 1.25 dihydroxy vitamin D (Rocaltrol) to treat patients who cannot one-hydroxylate vitamin D to form this active hormone. It is used in hypoparathyroidism and chronic renal failure. We also have several patients on "open-loop" insulin pumps to assist with diabetic management.

Given the significant advances in diagnostic techniques, therapies, and monitoring techniques of the past twenty years which have led to such dramatic improvements in the management and care of our patients, it certainly will be interesting for us to review the further advances in endocrinology another twenty years from now. □

Clinic Presentation

On the Front Line

Medical Ethics in the Intensive Care Unit

by George J. Heymach III, M.D. '76, Ph.D.

Physicians who admit and care for patients in intensive care units are called upon to provide for both the physical and mental well-being of their charges, including guiding them, where appropriate, on life support and extraordinary means of support.

Although some have likened the intensive care unit to a "humanistic wasteland," I would argue that in many ways it is the last place in inpatient medicine where some of the classic virtues of the "art of medicine" can be practiced. Few places in a hospital allow such intimate and meaningful relationships as are often fostered in the ICU. If the patient is awake and alert, a one-on-one relationship is often established between the patient and the nurse, consultants, or other health professionals such as chaplains and social workers who are involved with the patient's care. If the patient is not awake, families become even more intimately involved because there are frequently life/death situations to be dealt with. As you might imagine, many ethical questions are raised, and procedure-oriented issues come into focus.

Five ethical principles guide our health care: beneficence, or acting to benefit patients by sustaining life, treating illness, and relieving pain; nonmaleficence, or refraining from harm; autonomy, or respecting the right of patients to determine much of their medical care (a largely Western concept); disclosure, or providing adequate and truthful information so that competent patients can make decisions; and finally a relatively new concept, social justice, or allocating medical resources fairly (whatever that means) and according to medical need. This last might be termed a "soft" ethic. It will become harder as our resources dry up.

A doctor/patient relationship based on the above principles is relatively easy to maintain when primary physicians follow up patients in their offices or hospital rooms. It's sometimes much more difficult in intensive care units where the stresses and strains of emotions play a greater role. It is useful to attempt to apply the five ethical principles to common critical care issues:

Medical Decision Making

Ideally, decision making is carried out between the patient and the physician, or alternatively between a surrogate and the physician. In Pennsylvania we still are without a viable living will law, but we do have something called durable power of attorney, and I would submit

that the durable power of attorney law permitting someone to control his or her medical care as long as he or she is competent, but assigning control to someone else once the individual loses such competence, is perhaps a more rational way of handling the situation. Many of the living wills say something like "Under no circumstances should I be placed on life-support systems." I would submit that such a statement, precluding artificial ventilation or resuscitation under any circumstances, is not only unethical but ridiculous. The seventy-year-old man who is otherwise in good health but who gets a flailed chest from an automobile accident should certainly be resuscitated despite the fact that he may require an intervening tracheostomy. Unless there is an underlying disease, and as long as there is reasonable expectation for returning to good health, why not? Yet a living will might preclude such an action.

Hospitals and physicians are gun-shy; we're all afraid of being sued. We'd rather wait for the courts to make rulings for us. The courts would rather not make rulings for us; they say, "Practice good medicine."

Informed Consent

The ethical principles involved in informed consent are autonomy and disclosure. In emergency situations we have implied rather than informed consent. An undesirable way of getting around informed consent is to wait until it becomes implied—that is, when the patient becomes comatose. This practice, which many of us have seen at one time or another, really abuses beneficence. Informed consent also requires that if a patient dies we not have residents practice intubation or other procedures postmortem. Such actions require informed consent even though the practice would not harm a living person.

Resuscitation

"Do Not Resuscitate" status is frequently difficult to broach because the question arises at the most critical of times. Communication with the patient or the surrogate by the private physician and the specialist is important. Frequently I, as a pulmonary critical care physician, would like to say, "Let the attending physician discuss it with the family." The attending physician is there praying that you have already discussed it with the family because he really is over his head and does not know how to address many of the subjects. And so it becomes important that we act as a team in talking and working with the family, and not abnegate the responsibility that we have towards the patient. Classic candidates for no cardiopulmonary resuscitation (CPR)—and it's difficult to say what "classic" candidates are—would include a patient with an underlying malignancy who suffers severe trauma; and a patient with multisystem organ failure in whom the statistical likelihood of any survival or return to functional capacity is low. Some physicians cannot deny CPR to anyone. That's their ethical belief; everybody gets the most effort. If such doctors feel they are being ethically compromised, they have the choice of withdrawing from the situation and getting another physician involved. Some physicians, on the other hand, would argue that you don't have to offer CPR to anyone at all. They take a 180-degree approach.

"Brain Death" and Organ Transplantation

The only ethical question I'd like to raise in connection with organ transplantation is the matter of what happens when the patient dies and the surrogate or next of kin says, "I don't want you to touch Mom even though she was willing to give up her heart and lungs and pancreas." The answer is that despite an expressed, spoken, or written wish of the deceased, most transplant units will not harvest organs in such a situation because they really don't want to get involved even though they may have the legal right to do so.

Withholding and Withdrawing Life Support

Withholding life support is a real bugaboo. It is a situation that I become intimately involved with many times every day. Again some physicians feel obligated to sustain life at all costs, and with these physicians it's better not to get into debates because it's an ethical belief that they have, and they are entitled to their beliefs.

A competent patient can refuse treatment, but an adult cannot refuse treatment for a minor. As an example, a thirteen-year-old girl came into the emergency room and was admitted to the intensive care unit. Her family were devout Jehovah's Witnesses. She had a hemoglobin of five and a rip-roaring hemolytic anemia. The family refused transfusion, but we transfused the patient. You cannot deny care for a minor, and despite religious or other beliefs a minor cannot give up his or her rights.

Many state courts have upheld the legality of limiting care that provides no benefit, or is or was not wanted by the patient. Withholding and withdrawing are ethical equivalents, and this becomes difficult in terms of ventilator management. When we have ventilators going can we take them off? The answer is yes.

Don Walker

Dr. Heymach is a Clinical Assistant Professor of Medicine at the University of Pittsburgh, and Medical Director of the Intensive Care Unit and Step-Down Unit at Jefferson Hospital in that city.

Hospitals and physicians are gun-shy; we're all afraid of being sued. We'd rather wait for the courts to make rulings for us. The courts would rather not make rulings for us; they say, "Practice good medicine." You are not obligated to do something against your own intrinsic ethical structure and value system. A twenty-two-year-old girl came into the hospital in status asthmaticus, and was admitted to the intensive care unit. She said, gasping, "Under no circumstances am I to be placed on a ventilator. I don't want it. I saw my father die that way. I don't want to be placed on a ventilator." She was developing respiratory acidosis and losing consciousness. She had no underlying diseases. The physician intubated the patient, recognizing that he was doing battery to this woman, and accepting and understanding that he could be arrested for doing so. One should not undertake such heroics thinking that the patient is going to come back and say, "Thank you for keeping me alive." On the other hand, you don't have to follow something that in your ethical belief is contrary to what is correct. These are difficult situations—they're just not black and white.

Allocation of Medical Resources

Allocation of resources is one of the most difficult of issues. An Oregon plan under which everybody will have health care, but those who have more money will have better health care, is sort of a modification of what we have now. That is, now everybody in one category has health care, other people have better health care, and thirty-two million have no health care. The Oregon plan is a problematic alternative, and at some point the federal government will intervene.

Rationing of Health Care

Rationing is an ugly word, but how do we get more slices out of the pie of resources? I don't have an answer for that.

There are now many ethicists involved with medicine who identify and analyze clinical problems, facilitate negotiations, assist in problem resolution, and teach. Nevertheless, medicine is getting no easier, and from our standpoint in pulmonary critical care, each day presents an ethical quagmire. □

Clinic Presentation

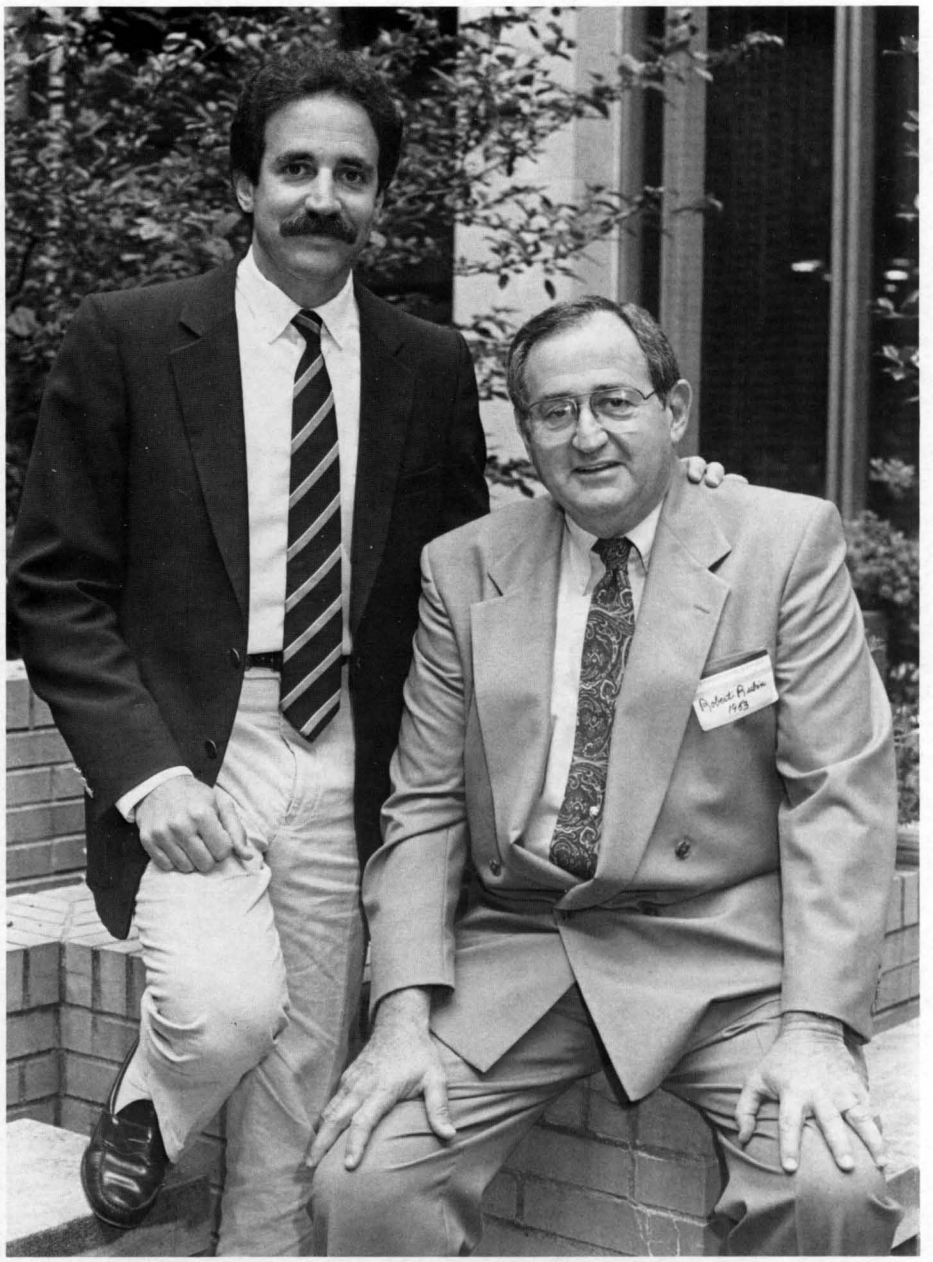
Advances in Medicine

by Mark G. Rubin, M.D. '81

This past decade has been a time of tremendous change for all of us, both professionally and personally. Family units have been formed or dissolved, and tiny Jeffersonians of the class of 2010 have been born. We have all chosen our respective fields of medicine which, one would hope, are those where our greatest expertise lies. Many of you are already creating a name for yourselves as leaders in your fields.

But, as in the expression, "Life is the experience you have while you are planning on how it is supposed to be," many of the changes we've been through have not been planned. Some are part of the natural order of the universe; others are related to the progress of our careers.

Some of the most significant changes in the practice of medicine have been looming over us since our days at



Don Walker

Dr. Rubin, joined here by his father, Robert J., '53, is a dermatologist in private practice in Solano Beach, California and Kauai, Hawaii.

Jefferson. I can remember clinical professors talking about the coming of socialized medicine and how sad it was that we, the Class of '81, would have missed out on the golden age of medicine, when doctors ruled the land sort of like dinosaurs in the Pleistocene. Sadly, both species of rulers are now extinct.

Fortunately for us these changes have been gradual and fairly easy for us to take in stride, but there has been a steady infiltration of bureaucracy into medicine. The most obvious changes are DRGs (diagnosis-related groups) or the new relative value scale. The loss of control over our professional lives is ubiquitous. A twenty-year-old receptionist in the medical records department has the ability to take away your staff privileges for failing to sign a chart within twenty-four hours of a patient's discharge—even if you are the head of the department. The American Medical Association is telling us that we can't be trusted to make our own ethical decisions and now they have to institute guidelines telling us what we are allowed to accept from pharmaceutical companies.

For this presentation I have been asked to discuss recent advances in medicine. Now let's be serious here. I'm a dermatologist. We are not usually considered to be pioneers blazing new paths through the frontiers of medicine. Although there have been many significant advances in the field of dermatology, most of you couldn't care less unless you are afflicted with one of those diseases. After all, you already know dermatology: if it's dry, wet it; if it's wet, dry it; treat everything with topical steroid creams, and after the patient becomes a real mess refer him or her to the dermatologist.

The field has become more than treating warts and popping pimples. Remember that the skin is the largest organ of the body. Dermatology has expanded to overlap other fields, including immunology, pharmacology, and even cosmetic surgery. Our specialty is not alone. All of medicine continues to change, and if you recall the first lecture by Wolfgang H. Vogel, Ph.D., Professor of Pharmacology, and of Psychiatry and Human Behavior, in 1977, he stated that over one-half of what we'd be taught would be useless or wrong, but unfortunately nobody knew which half. Well, that's still true, and one-half of what we are learning now is still wrong. This underscores the importance of continuing our education, striving for new developments, and challenging the accepted dogmas when things no longer make sense.

As the field of medicine changes, so does our perception of medicine. I think one of the most important challenges that faces us as physicians is our lack of respect for the fraternity of medicine. Whether we like it or not, we are all part of this group. Our individual actions as physicians are reflected in the way the public perceives the field of medicine. Sadly, during the 1980s "ME" decade, many specialties in medicine became more concerned about themselves and their immediate future than about the direction and future of medicine as a whole. The fallout of this is that we have witnessed turf battles among specialties over who should be allowed to treat what, rather than what is best for the patient. We also see jealousy and animosity among some physicians because of their widely divergent salaries based on geographic location and specialty.

Some of these self-centered actions may in the end destroy the honor and pleasure of being a physician in this country. As a group we need to be concerned about our future as practitioners of the art and science of medicine. We must stand united against the concept of becoming purveyors of health care units in an assembly line of medical care. Anyone, even a computer, can be trained to make a diagnosis and treatment plan, but the value of compassion, humanitarianism, and downright concern for another human being cannot be overlooked. These are the traits that Jefferson has tried to instill in all of us, and this is what makes us healers. Losing sight of this and getting caught up in the business of medicine is what may prove to be our downfall.

The basic reward for helping another human in need—whether the problem is an acute myocardial infarction or an "under grounder"—will never change, and hopefully that is still what motivates us. This is a feeling that must be nurtured during long nights on call or when your office is running one hour behind schedule, but it is the feeling that helps us fight off cynicism and burnout. Most importantly it is what differentiates us from other professions. We are part of the fraternity of medicine. □

Clinic Presentation

Annual Checkups?

by Gregory Mokrynski, M.D. '86

In discussing the role of the annual checkup, or more appropriately the periodic health examination, my goals are severalfold. First, to emphasize that in this day of subspecialty practice patients may assume that the role of their primary physician is to be undertaken by their specialist. Thus, all physicians have a responsibility to practice preventive medicine.

Second, to underscore the importance of preventive medicine as opposed to the physician's perceived reactionary role wherein a patient presents with a particular problem and we diagnose, treat, and follow up. The periodic health examination or preventive visit should effectively alter this image of the physician's role.

Third, to replace the rigidity imposed by the typical annual physical examination, and its accompanying battery of standard laboratory tests, with the flexibility of periodic health examinations in which interventions and time intervals are based on those diseases, accidents, behaviors, and psychosocial development patterns that vary according to the different stages of our patients' lives.

Finally, to state empirically that preventive medicine is effective medicine.

Preventive medicine may be described as interventions including history, physical examination, screening tests, counseling, immunizations, and prophylactic drug administration given to asymptomatic patients based on age, sex, and risk categories, and guided by recommendations from clinical research, professional health organizations and agencies, and personal experience, that result in reduction of morbidity and mortality.

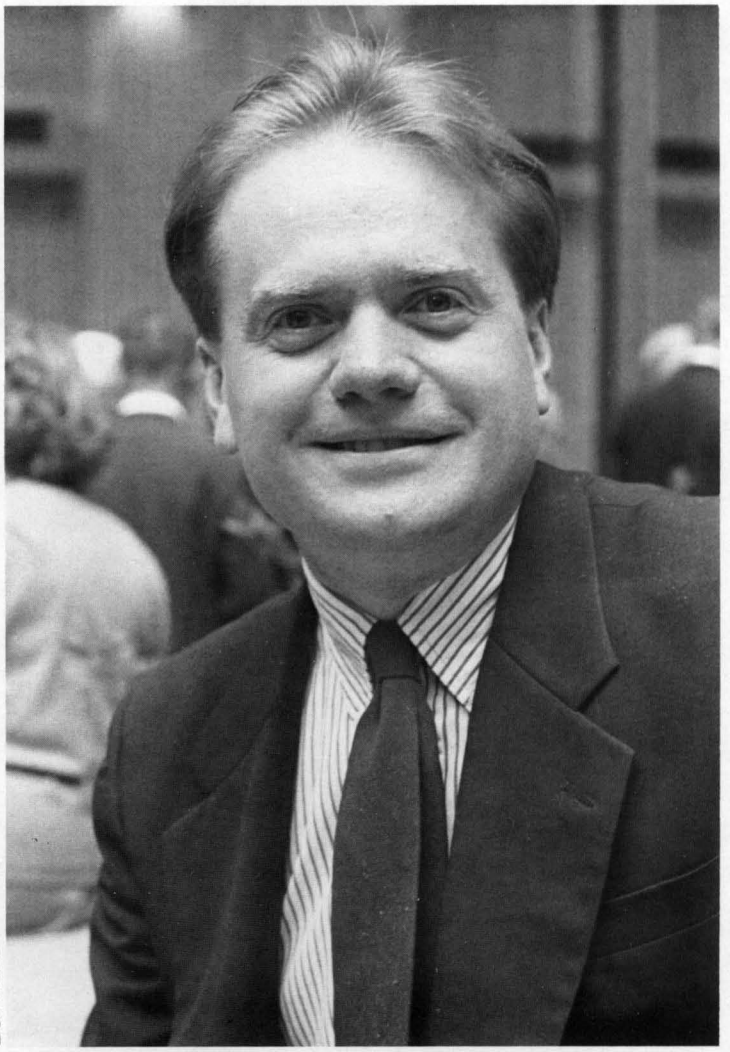
Although the concept of preventive checkups is sound and old hat (the annual physical examination was first endorsed by the American Medical Association in 1922 and reevaluated as the "periodic visit" in 1983), many patients view it as an ill-defined abstract.

The vast majority of office visits, and (one hopes) today all hospital admissions, are precipitated by illness or injury. The golden opportunity for initiation of preventive measures and formulation of

a well care plan, however, is with such contact. The initial history and physical is usually the most comprehensive, and will allow for identification of risk factors. More importantly, the patient is most receptive to intervention and long-range health planning when the realities of illness and its imposed restrictions have struck home.

One needs to devise individualized preventive programs. The physician must be aware of the leading causes of death and disability in the patient's age, sex, and socioeconomic groups. A selection of laboratory tests and diagnostic procedures is derived from this information, and from appropriate use of data from the history and physical examination. Counseling is then initiated concerning diet, exercise, substance abuse, sexual practice, injury prevention, dental health, and mental health in addition to early detection methods for various diseases.

Without patient and physician enthusiasm preventive medicine will not work, because much of the emphasis is placed on behavior and behavior modification. By addressing preventive therapy, or reduction of risk factors, in areas of substance abuse, poor nutrition, and physical inactivity, we have the potential to improve our patients' well-being far more than the benefits gained simply from routine screening for early intervention in the disease state. The insurance applications and examinations serve as illustrations. In the office or hospital setting there is a tendency to gloss over the social history and to employ a shotgun approach to laboratory studies. We order many tests, but I have rarely seen a nicotine level drawn except for a health insurance physical. The insurance companies, for obvious reasons, are much more direct and to the point. They screen for specific factors that effectively and adversely alter the quality and quantity of life, and then categorize their customer/client based on age, sex, and behavior patterns in addition to specific illnesses and injuries.



Don Walker

Dr. Mokrynski is an Instructor in Medicine at Jefferson.

The patient is most receptive to intervention and long-range health planning when the realities of illness and its imposed restrictions have struck home.

Some comments are in order concerning screening tests. We can do more harm than good, particularly with labeling, if studies are generalized and not selected. Given particular clinical settings few would argue the effectiveness of screening procedures, e.g., mammography, Papanicolaou smears, or cholesterol levels, in reducing morbidity and mortality. However, there is a tendency to overuse these while ignoring the patient's individual risk profile. The two major problems incurred are expense and the fact that no test is a perfect indicator. We must be aware of the efficacy of a screening test as defined by accuracy (sensitivity, specificity, and positive predictive value) and reliability, or reproducibility.

I have purposely avoided specific recommendations for the timing and content of the periodic health visit as this must be tailored to the individual patient and underlying conditions. Reasonable flow charts, with background information, are offered in several sources. These charts may be posted in the office or even given to the patient to enhance both physician and patient compliance.

Thus the annual visit is not obsolete, but rather more directed. We need to place increased emphasis on counseling. We must remain flexible regarding follow-up visits and integrate health maintenance, disease prevention, early detection of illness, and effective intervention. The periodic health examination thus appropriately replaces the annual physical examination.

We all are responsible for educating our patients, especially for conveying the impact of preventive medicine on the quality and length of their lives and perhaps our lives also.

References

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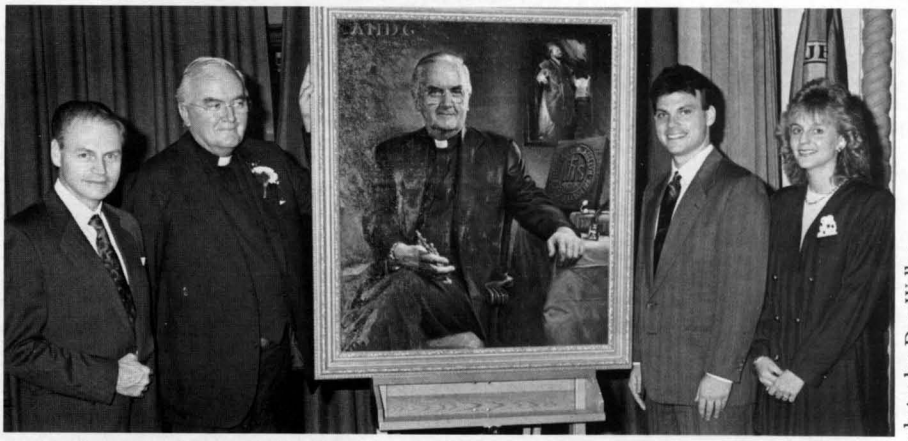
Senior Class Honors Counselor, Physician, and Friend



photos by Don Walker

Artist Dean Paules with Fr. Bradley and Portrait Committee Cochairpersons Mitchell I. Edelson and Michelle D. Vichnin of the Class of '91

At this year's Senior Class Portrait Presentation on May 6, and at a Baccalaureate Mass on June 6, the senior class distributed their adaptation of the "Song of Thanksgiving" by Darryl Ducote, dedicated to Edward Charles Bradley, S.J., M.D. '55, Special Counselor in Residence, and Clinical Associate Professor of Medicine. Class members sang the song at the end of the Mass.

Fr. Bradley's classmate, Herbert C. Cohn, M.D. '55, Professor of Surgery, spoke of the courses they had charted in medical school and beyond. Portrait Committee Cochairpersons were Mitchell I. Edelson and Michelle D. Vichnin of the Class of '91. Joseph S. Gonnella, M.D., Senior Vice-President for Academic Affairs and Dean, accepted the painting by artist Dean Paules on behalf of the Medical College, and University President Paul C. Brucker, M.D. accepted it on behalf of the Board of Trustees.

Joseph F. Majdan, M.D., Clinical Assistant Professor of Medicine, presented a biographical sketch. A native of Philadelphia, Fr. Bradley was graduated from Saint Joseph's Preparatory School. Accepted as a midshipman at the U.S. Naval Academy, he declined that appointment to enter the Jesuit novitiate, a year of reflection which was to influence his entire career. He did not continue with the Jesuits at that time, but entered Saint Joseph's College, and later Jefferson Medical College. Residency in internal medicine at Pennsylvania Hospital and at Lankenau was followed by fellowships in cardiology at the University of Göteborg, Sweden, and at the National Heart Institute in London. While in Sweden Dr. Bradley performed and published the first cardio-conversions of atrial arrhythmias in Europe, after Lown's landmark work on the electrical conversion of atrial fibrillation.

Returning to the United States, Dr. Bradley joined the faculty of the University of Southern California, where he was appointed Director of the Shock Research Unit, the first of its kind in the world. In this position he authored or coauthored numerous articles, and was the first to use the alpha blocker phentolamine in the treatment of myocardial infarctions and low-output shock.

During this time he learned of a Jesuit priest in Vietnam who was in need of medical supplies and assistance. Dr. Bradley set out not only to gather supplies, but to go to Vietnam himself for a two-month period. Armed with a crash course in tropical medicine and parasitology, he traveled by 707 transport plane, helicopter, and sampan to the village of Tram Chin. There, he journeyed through the countryside by motorcycle, getting to know the people of Tram Chin and another village, Hao Binh. He opened a clinic, where he analyzed gram stains and blood smears with a microscope lit only by sunlight. He saw the scourges of war, and alarming incidence of polio and tuberculosis.

Dr. Bradley returned to the U.S. determined to have the people in those towns vaccinated against polio. When organizations seemed unresponsive, he turned to President Nixon. Five U.S. Army helicopters filled with medical supplies and medical personnel swept through Tram Chin and Hao Binh, innoculating approximately 8,000 people against polio. Follow-up indicates that polio was eradicated in these two villages.

Twenty-seven years after leaving the Jesuit novitiate in Wernersville, Pennsylvania, Dr. Bradley returned there in 1974, a decision he describes as the most important and happiest of his life. He was ordained a Jesuit priest in 1979. After his ordination Fr. Dr. Bradley opened a medical practice in North Philadelphia to care for the poor.

In 1987, at the invitation of Dean Gonnella, he moved to Orlowitz Hall as Special Counselor in Residence at Thomas Jefferson University, where he is available twenty-four hours a day to counsel members of the Jefferson community. He also serves as a member of the Medical College Admissions Committee, and teaches a course in medicine to third-year students, as well as being a consultant two days a week to Jefferson's Health Maintenance Program for former cardiology patients.

Fr. Bradley's words to the Class of '91 on May 6 could be appropriate to anyone reflecting upon a medical career: "A gift given in love is never lost, never diminished. It is only more deeply possessed. Our profession is such a gift, for it is not merely a trade, dependent on intellectual acumen and technical skill. It is also a matter of the heart, the spirit, for we deal with, not things, but persons, with needs and hopes and yearnings akin to our own.

"In this portrait are several symbols of ideals which I embrace and strive to fulfill. Our ideals differ, naturally, and each of us holds to our own. You, the Class of '91, have known me to be a priest of the Jesuit Order and a physician. You have accepted me for who I am. You give great compliment to the profession of medicine, for in what other profession can and should the ideologic, racial, social, political, and religious differences between persons disappear from view? Each of you possesses a great gift to give to the people of this world, wherever your journey calls you. Reflect often on this profession of ours as a gift to be given and a blessing to be shared. Have a wonder-full life"—a life full of wonder.

—*C.J.T.C.*

Fr. Bradley's mother, Marie W. Bradley, attended the presentation ceremony.

Portraying a Dean with Far-Ranging Interests

Jefferson honored one of its most outstanding and popular leaders on May 31. A portrait of Joseph S. Gonnella, M.D., Senior Vice-President for Academic Affairs and Dean, was presented to the University recognizing his twenty-four years of service, the last seven as Dean of the Medical College during an exceptional period of growth both in physical plant and in research capabilities.

Robert L. Brent, M.D., Ph.D., Distinguished University Professor, Louis and Bess Stein Professor of Pediatrics, and Chairman of the Department, presided at the ceremony with humor that reflected his long and flourishing association here with Dr. Gonnella.

Born in Pescopagano, Italy, Dr. Gonnella enjoys dual citizenship through a family tradition of migrations to and from America. He is a summa cum laude graduate of Dartmouth College, where he was elected to Phi Beta Kappa, and is a graduate of Dartmouth Medical School. He received his M.D. degree from Harvard Medical School.

Internship at the University of Illinois Research and Educational Hospitals was followed by residency in medicine there, where he also was a fellow under George E. Miller, M.D., then Director of the Office of Research in Medical Education. Dr. Miller was present at the portrait presentation. He told the audience that Dr. Gonnella had been "well on his way to a distinguished career as a clinician and scientist" when the field of medical education drew his attention. His first paper, published in the *New England Journal of Medicine* while he was a resident, was "Mastocytosis Manifested by Hepatosplenomegaly." He published four more papers of this type during residency—the last, "Pancytopenia and Death," in the *Archives of Internal Medicine* in 1966—before turning to research in medical education.

Dick Bell

Joining Dr. Gonnella at the presentation are, from left, Dominic Miranda, M.D., the Dean's brother-in-law; Robert Gonnella, his son; Marie Miranda, his sister; Linda Gonnella; Maria (Mrs. John) Gonnella; his daughter, Mary; and his son, John.

Dr. Miller spoke of Dr. Gonnella's "calm pursuit, while others moved from crisis to crisis." He also quoted another faculty member who recalled that, as a senior resident responsible for grand rounds, Dr. Gonnella had always introduced the problem by explaining something about the patient as a person. "He taught by what he did, not just by what he said."

As he has expanded his studies of the process of undergraduate, graduate, and continuing medical education, Dr. Gonnella has stressed the importance of linking education to the services which graduates are expected to provide. He brought this perspective with him when he returned east in 1966 to join the late William F. Kellow, M.D. at Hahnemann Medical College. One year later Dr. Kellow accepted an appointment as Dean and Professor of Medicine at Jefferson Medical College, and Dr. Gonnella came with him as an Assistant Professor of Medicine and Assistant Dean.

He assumed the directorship of a newly established Office of Medical Education here in 1969 as Associate Dean and Director of Academic Programs. This office soon instituted a longitudinal study of Jefferson students, a continuing resource which has achieved national prominence. In 1983 he was named Dean for Educational Programs and Director of the Center for Research in Medical Education and Health Care, and in that same year, Acting Dean of Jefferson Medical College. The following year Dr. Gonnella was named Vice-President of Thomas Jefferson University and Dean of Jefferson Medical College, and in 1989, Senior Vice-President and Dean. Frederick B. Wagner, Jr., M.D. '41, The Grace Revere Osler Professor Emeritus of Surgery, and University Historian, has noted that in the course of his appointments here Dr. Gonnella has "taught medical students and house staff, been counselor and financial aid officer to medical students, been responsible for curriculum evaluation and development and for guidance and letters of recommendation for Jefferson students for postgraduate training, served on and chaired many faculty committees, and been prominent in extramural, local, national, and international activities." Dr. Gonnella's interest in the whole of the University is symbolized by his choice of Dr. Wagner's book, *Thomas Jefferson University: Tradition and Heritage*, to be included in the portrait by Dean Paules.

Dr. Gonnella has placed a high value on compassion and integrity as well as academic excellence, while maintaining the always difficult balance among teaching, patient care, and research. He has contributed very significantly to the recruitment of outstanding faculty and to the development of new facilities for basic and clinical investigation. In his address to the sophomore parents this spring he pointed out that strong research programs attract top faculty, who can provide the best teaching to students, and also draw sizeable grants to the institution.

He meets regularly with the freshman and sophomore classes to hear their thoughts and concerns about the first two years of medical school. Joseph F.

CONTINUED ON PAGE 34

A RESEARCH BUILDING *for* BUILDING RESEARCH

by Malcolm Clendenin

photos by Dave Super

A BOLD NEW STRUCTURE HAS RISEN ON CAMPUS that houses Jefferson's burgeoning research in molecular biology.

The Bluemle Life Sciences Building is the first Jefferson has built for basic science since Alumni Hall in 1968, and among the first in the nation specifically for molecular biology. Jefferson's external research funding is expected to total $52 million annually at the end of this academic year and roughly $70 million by the mid-nineties.

Ground was broken in July 1989 for the $86 million project (named in honor of former University President Lewis W. Bluemle, Jr., M.D.) at the northeast corner of Tenth and Locust Streets. Its size and goals were determined by a campus master plan completed in 1987 with the help of Geddes Brecher Qualls Cunningham, a Philadelphia architecture firm, and Earl Walls Associates, a San Diego firm specializing in lab planning. Major growth in the foreseeable future, the master plan indicated, should take place to the east, between Ninth and Tenth Streets. Lab research should be located in the the southern portion of the campus, in and near Alumni Hall, while patient-related activities should be located to the north, adjoining the Gibbon Building, and activities such as education and administration should be focused at the center.

The Bluemle Life Sciences Building's 290,000 gross square feet include 151,000 net square feet of lab space and house six hundred persons, including sixty principal investigators. The ground floor contains three high-ceilinged multipurpose conference/lecture rooms—one that seats 145, with an adjacent room for audiovisual equipment, and two that seat eighty each and can be joined via a sliding divider. The second through tenth floors include labs, offices, seminar rooms, and service space for glass washers, autoclaves, centrifuges, cold

From Scott Plaza, with Orlowitz on the left

An Indication of Future Work?

One of the research teams that will occupy the Bluemle Life Sciences Building is that of Carlo M. Croce, M.D. In May, Dr. Croce announced the discovery of a gene that may be largely responsible for lung cancer, at the opening symposium of the eighty-second annual meeting of the American Association for Cancer Research in Houston. He stated that scientists should know "within one or two years" which genes cause lung cancer.

The team is concentrating on the PTP-gamma gene, thought to suppress the growth of cancerous tumors in the lung. This gene is absent from the cells of many patients with lung cancer, permitting cancer to grow uncurbed. Dr. Croce explained that several genes are probably responsible for the formation of the cancer, but that the PTP-gamma gene appears to be particularly significant. He stated, "If it's not this gene, then it's very close to it." The PTP-gamma gene is located on chromosome three, which is thought to contain several genes involved in lung cancer.

If the discovery is supported by further investigations, it could result in diagnostic tests and treatments for the disease.

rooms, dark rooms, and tissue culture. Sophisticated equipment comprises DNA synthesizers and automated sequencers, and animal facilities including transgenic mice. The basement and penthouse are dedicated to mechanical and electrical systems. Paramount in the design were the exacting needs of molecular biology techniques: air circulation, fume exhaust, containment, limited vibration, and safety.

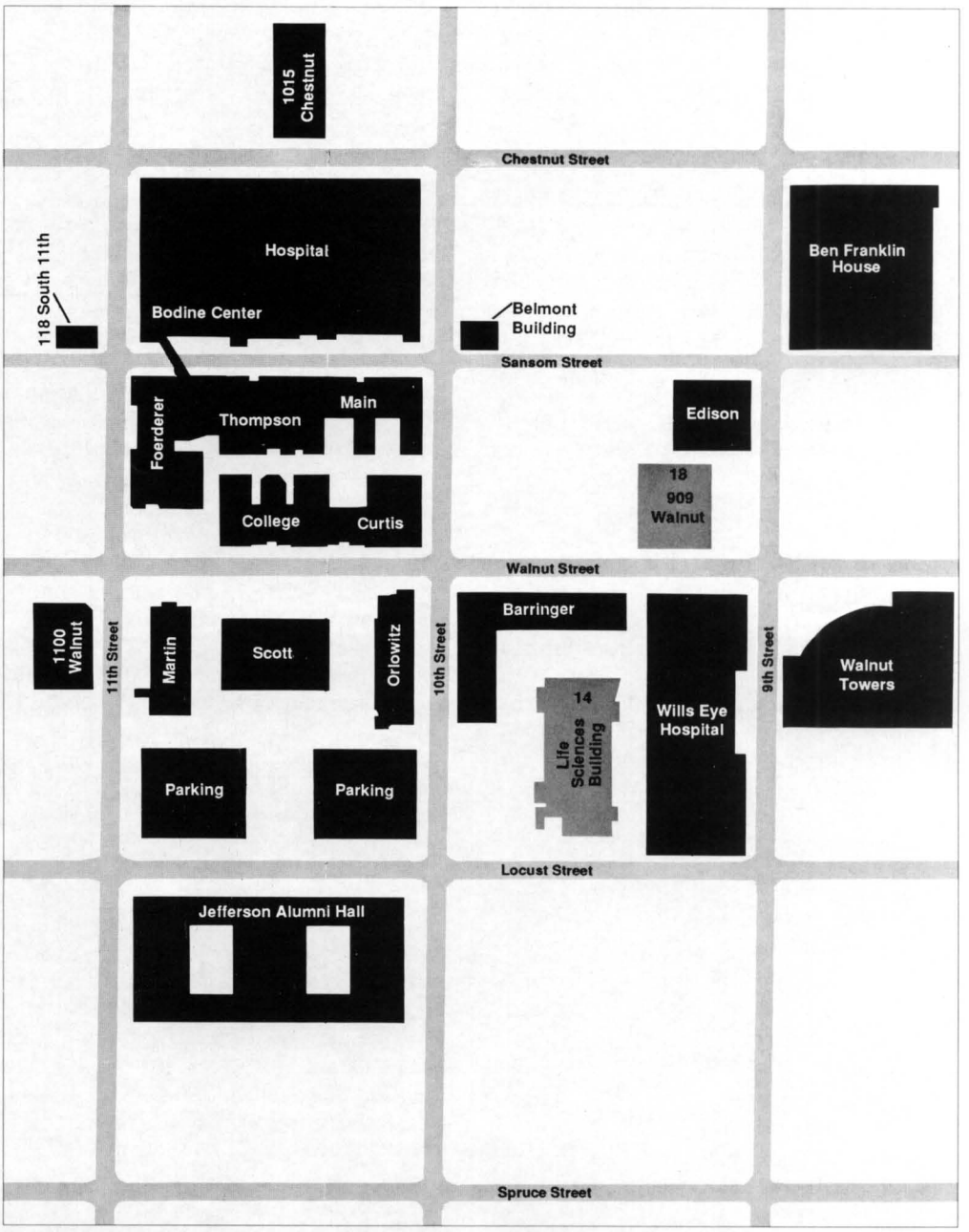
The structure includes space for teaching. Each lab floor has a library/seminar room and an informal lounge to accommodate interaction among students and faculty. The nationwide emphasis on training in molecular biology is reflected in the Medical College: in the past few years, a large fraction of entering freshmen have volunteered to attend special lectures on molecular research given by members of Jefferson's Institute of Molecular Medicine.

The new facility has permitted a much-needed campus-wide reorganization of teaching space, with the goal of increasing the integration of clinical teaching and research with basic science. As departments have moved from Alumni Hall into the Bluemle Life Sciences Building, room has become available for others. Pharmacology is now located on the fourth floor of Alumni Hall nearer the Department of Physiology, with which it works in cardiovascular and cardiopulmonary research. The Department of Pathology and Cell Biology has more lab room adjacent to its previous location on the second floor, and the Department of Medicine's Division of Environmental Medicine and Toxicology is closer to Clinical Pharmacology and the Division of Endocrinology and their related research. Several clinical research programs, including hematology, cardiovascular and pulmonary diseases, neurosciences, and liver disease and alcohol, are moving closer to the basic science labs. New teaching spaces have become available for all the basic sciences.

The Research

The second and third floors and part of the fourth in the Bluemle Life Sciences Building are occupied by the Department of Biochemistry and Molecular Biology and the Institute of Molecular Medicine. The Dermatology Department is also on the fourth floor, while the fifth contains the Rheumatology Research Division of the Department of Medicine. These entities form one of the world's largest groups for studying the molecular biology and genetic disorders of connective tissue. Among their discoveries is the demonstration of how collagen fibrils grow; the system for fibril formation has laid the foundation for determining how mutations that cause synthesis of structurally abnormal collagen molecules produce their deleterious effects. Institute members recently announced that mutations in the two genes for Type I collagen cause osteogenesis imperfecta. The institute also studies the genetic basis for diabetes, heart disease, osteoporosis, vascular aneurysms, Krabbe's disease, and metachromatic leukodystrophy. In addition, the institute investigates the mechanisms of action of important molecules within cells, studying DNA topoisomerases, growth factors and oncogenes, regulation of gene expression in tumor viruses, the molecular basis of embryonic development in drosophila, and the molecular basis of rearrangements of human chromosomes.

The Dermatology Department has a five-year, $4.7 million National Institutes of Health grant for a study of "Molecular



The Campus
North is toward the top.

Dedication and Symposia Celebrate Opening of Building

The Bluemle Life Sciences Building will be dedicated at a ceremony on October 7. Also, scientific symposia will be held this fall at the building to celebrate its opening. The Department of Dermatology will sponsor "Epidermolysis Bullosa: Molecular Biology and Pathology of the Cutaneous Basement Membrane Zone" on October 4 and 5 (for further information, contact the department at 450 Bluemle Life Sciences Building, 215 955-5785). On October 23, Dr. Croce will present a symposium on "Genetics of Human Cancer." Dr. Litwack will present one on "Receptors and Signal Transduction" on November 20, and Irene T. Weber, Ph.D. will conduct a symposium on "Macromolecular Structure" on December 9. (For further information about these last three symposia, contact the Cancer Institute at 1050A Bluemle Life Sciences Building, 215 955-4645.)

The first seminar of the Cancer Institute and Cancer Center was presented July 19 by Mark Minden, M.D., Ph.D., Associate Professor of Medicine and Senior Scientist at the Ontario Cancer Institute, who spoke on "Regulation of Growth of Human Acute Myeloblastic Leukemia Cells."

Genetics of the Basement Membrane Zone in Epidermolysis Bullosa." Other projects include investigations in keloids and heritable connective tissue disease, such as Marfan's syndrome.

The Rheumatology Research Division is supported by a $3.1 million NIH grant to study the molecular biology of heritable osteoarthritis. The Division also investigates myocardial fibrosis, pulmonary fibrosis, an animal model for scleroderma, and studies of TGF-b, a human growth factor important in controlling scleroderma. A $1.1 million, five-year NIH grant supports a study of "Biochemical Alterations in Scleroderma." Investigators hope to uncover the mechanisms responsible for the increased production of collagen associated with this disease, and to learn what causes the increased levels of messenger RNA molecules for Types I, III, and VI collagen that they have found in fibroblasts from patients with scleroderma. They have discovered that patients with scleroderma have an abnormally high level of activated T-lymphocytes producing transforming growth factor beta, which has been shown to stimulate the production of collagen by fibroblasts. Also on the fifth floor of the building is the Stein Research Center, which houses researchers in pediatrics.

CAMPTOTHECIN, A DRUG THAT KILLS CANCER CELLS by interfering with their DNA, is currently being studied by Assistant Professor of Biochemistry and Molecular Biology Mary Ann Bjornsti, Ph.D. with a grant from the W. W. Smith Charitable Trust. Dr. Bjornsti is analyzing the molecular interactions of the drug and the cells and will use her findings to design a model for studying other similar drugs.

The Department of Microbiology and Immunology and the Jefferson Cancer Institute occupy floors six through ten. Chairing these entities is Carlo M. Croce, M.D., who studies chromosomes, oncogenes, and the molecular genetics of human cancer. He has discovered the involvement of immunoglobulin loci and the C-*myc* oncogene in Burkitt's lymphoma, and identified the gene, bcl-2, that is involved in follicular lymphoma. This has already found clinical application in the monitoring of residual disease in treated patients. Dr. Croce's team concentrates on basic research under the auspices of the Cancer Institute. They also undertake joint projects with clinical researchers interested in cancer; the Jefferson Cancer Center forms an umbrella under which both basic and clinical investigators function.

The Cancer Institute's investigators hold appointments either in Microbiology and Immunology or in Pharmacology. Chairman of Pharmacology and Deputy Director of the Institute is Gerald Litwack, Ph.D., whose research, supported mainly by the NIH, is on the mechanism of action of the glucocorticoid receptor, a key molecular element in the cellular adaptation to stress. Investigators in his department study receptors, signal transduction, and structural biology.

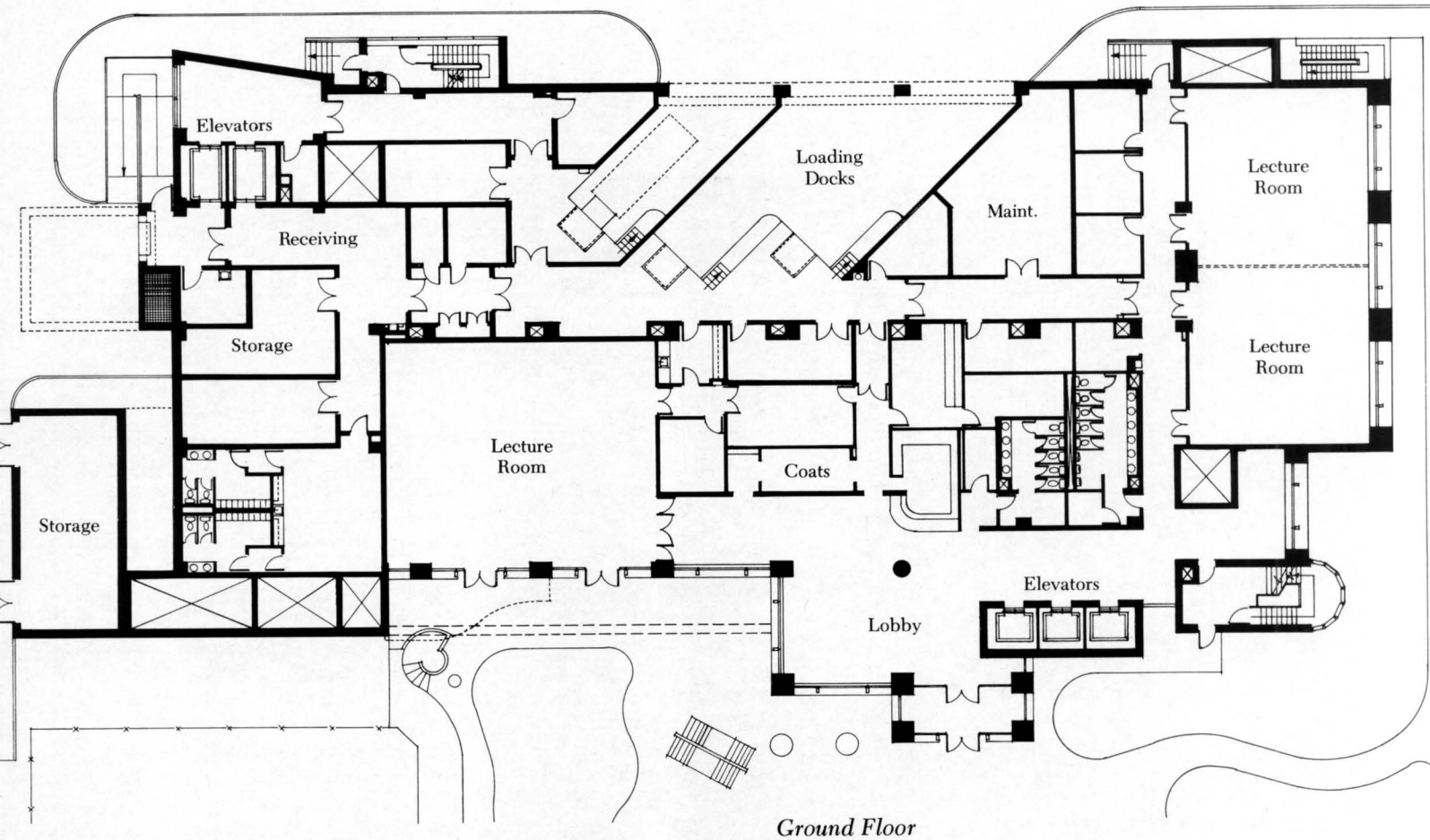
The Architecture

The Kling-Lindquist Partnership was a logical choice to design the large, complicated Bluemle Life Sciences Building. Jefferson took advantage of this local firm's full-service capabilities: it did the engineering and interiors, even furniture selection. TKLP has designed a number of lab structures in the past few years. And the same firm—though with different principal architects—designed Alumni Hall and the Foerderer Pavilion (1954) on Jefferson's campus, and the Lankenau Hospital complex, a Jefferson affiliate, near City Line Avenue.

Only half the site is covered by the Bluemle Life Sciences Building, leaving a forecourt to the west designed by environmental artist Alice Adams and called "The Roundabout." This will be described in the Fall *Alumni Bulletin*.

The building is of reddish-orange brick, made darker by large expanses of glass that appears nearly black. Floor levels are expressed in thick horizontal stripes of tile of a lighter orange. Orange brick has become standard for Jefferson

A room-sized rack washer

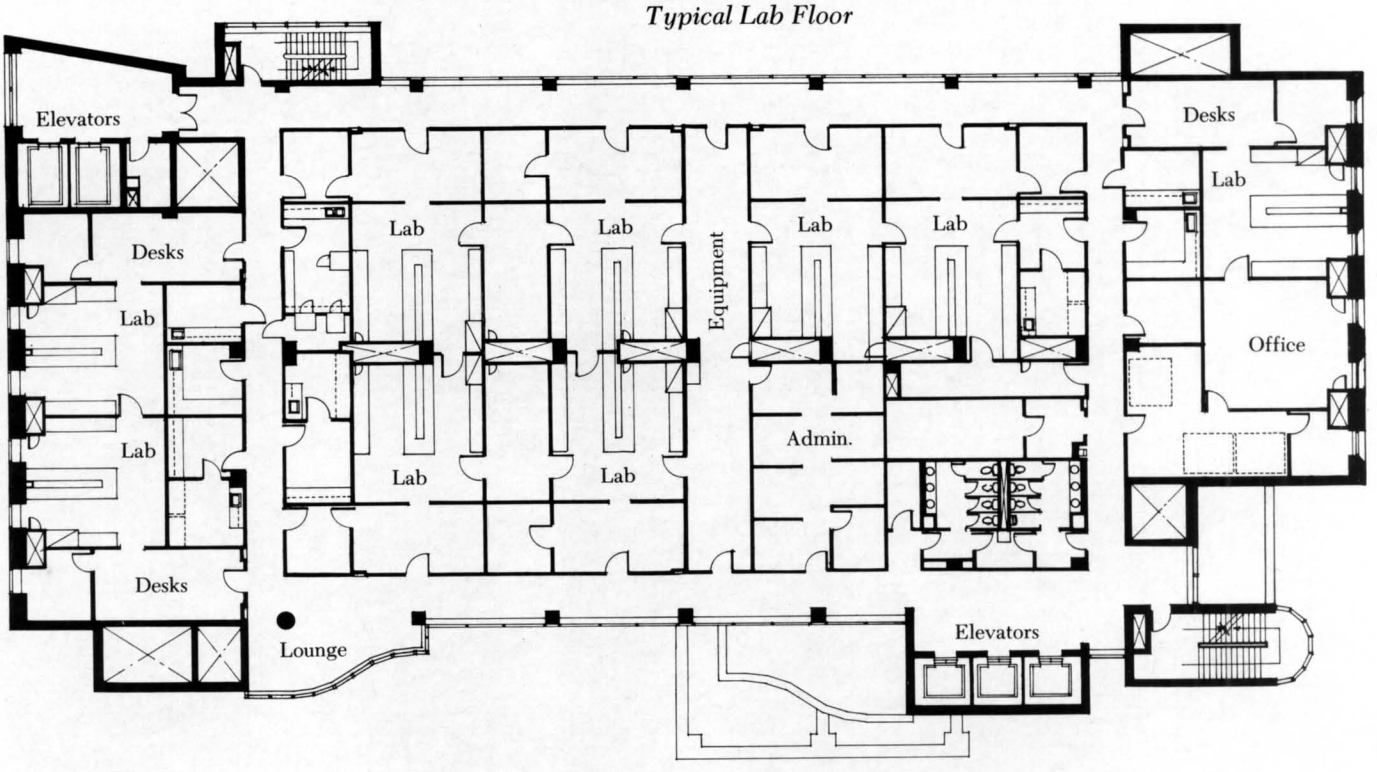


Ground Floor

Bluemle Life Sciences Building

North is to the left. One inch equals approximately thirty-two feet.

Typical Lab Floor



buildings, but the dark hue relates the new edifice specifically to the adjacent Barringer Hall and parking garages and the Scott Building, while the combination of dark and light orange recalls the Medical Office Building (1100 Walnut).

The bricks used in the new structure are very tall compared to their width, expressing the verticality of the structure; it is a slab similar in proportion to the College/Curtis Building, Orlowitz Hall, and the Pavilion. It has a more irregular shape, however, than any other structure on campus; in contrast to the blocklike Gibbon Building and Alumni Hall, the slab is broken by elevator towers, recessed windows, an acute angle at the northeast corner, and rectangular and curved bays and wings. On the north end is a low roofless wing concealing two huge tanks. "The curved forms soften the facade and make it more inviting," explains Eric Chung, F.A.I.A., Senior Design Principal at TKLP for the project. "The building needed to be humanized, not all square corners. And the curved forms are organic shapes, reflecting the biomedical work that goes on inside."

The facade looks toward the center of Jefferson's compact urban campus, and forms a visual terminus to the east, just as the adjacent block-long Alumni Hall, with its solid upper wall pierced only by slit windows, forms a southern confine. Loading docks at the rear of the new edifice are reached via a driveway from Locust Street to Walnut between it and Wills Eye Hospital.

The north end of the Bluemle Life Sciences Building runs behind one wing of Barringer, with which it forms a U shape sheltering a courtyard. Viewed from the center of campus, this end disappears in back of Orlowitz; a piano curve in the facade expresses the point where it becomes obscured, where it slips behind the other two buildings. The curve reaches out to these buildings in front of it.

The facade has a wide variety of ornamentation and fenestration. It is almost a perfect square, which the architects have deemphasized by dividing it into vertical masses, with protruding towers at both sides. They have also divided it into horizontal elements: the first-floor windows, topped with a mezzanine effect of small square windows within a band of color-patterned brickwork, form a base beneath a series of blackish band windows paralleling those on the Gibbon and Pavilion buildings. Near the top is a frieze of more of the patterned brick. Cast stone of a warm tan color is used for moldings, stringcourses, and a cornice.

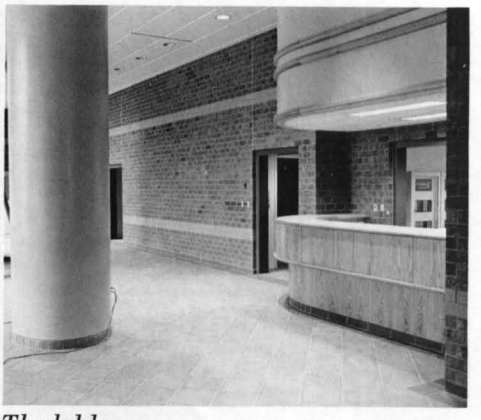
Along the top of the east and west walls are anodized aluminum grills encircling white lights that come on at night. Their narrow verticals contrast with the horizontal windows beneath, which glow at night with interior lights. The appearance is stunning then—the corner stairwell becomes a cylinder of light, and bright square windows are punched out against the night sky on

Structure and Function

Structural Biology Laboratory Featured in New Building

As part of the Cancer Institute, Jefferson will have a first-rate structural biology laboratory, a facility present in only a few research universities. The great potential in structural biology and molecular modeling has been identified as a priority by many scientific authorities. The laboratory, when in full operation, will have two molecular modelers, one protein chemist, two nuclear magnetic resonance researchers, and four to five X-ray crystallographers.

"The development of a strong structural biology group will introduce drug design as a major component of research at Jefferson," Dr. Croce explains. "An entire floor of the new building will be designated for structural biology where we will study the relationship between structure and function and by understanding the connection between structure and function, be able to create new structures that might have the function we are interested in." Dr. Croce believes that drug design will be crucial to the future of the pharmaceutical applications of scientific discoveries.—*Adapted from the* College of Graduate Studies News, *July 1991.*



The lobby

the south.

The lobby has an outdoor feel, with floor-to-ceiling windows, floors of rust-orange tile set diagonally, and walls of the same bands of dark and light orange as on the building's exterior; these bands flow unchanged around the exterior and interior sides of piers between the glass. Parts of the lobby project out into the plaza, further breaking the boundary between inside and outside. Glass doors in the adjoining conference room encourage guests at a function or symposium to walk outdoors.

Earth colors and textured materials differentiate the very public ground level from the lab levels with their white plasterboard walls and vinyl tile. Warmth is added to the upper stories by railings of blond oak in the hallways, recalling the railings on the mezzanine of Alumni Hall (which also has interior walls of brick like the new building), and blond oak doors throughout. They help give the building a more welcoming feel than most lab structures.

The upper stories have labs at the center surrounded by a corridor. On the east and west sides, it runs along the outside of the building and has a wall of windows; at the north and south ends of the building there are more laboratories to the outside of the corridor. Having the corridor around the perimeter instead of down the middle permits big blocks of space at the center—work areas flow together without the interruption of a hallway. As a lab's personnel grows, it can annex more rooms; the drywall construction is easily altered.

The architects have funnelled light into the interior in creative ways. Although

From the second-floor balcony

Along Locust Street

New Cancer Vaccine Developed at Jefferson Holds Promise for Patients with Advanced Melanoma

A team of researchers at Jefferson, headed by Associate Professor of Medicine David Berd, M.D., has developed an immunotherapy regimen that shows promise in the treatment of melanoma. The work was published in the May 15 issue of *Cancer Research,* and was presented at a meeting of the American Association for Cancer Research.

The early stages of study are hopeful. "This is the first type of cancer vaccine that has consistently induced an immune response in patients," says Dr. Berd.

The vaccine is made from autologous tumor cells that are processed, inactivated, and then injected back into the body. For unknown reasons, humans do not exhibit a defensive response when their own tumor cells are injected into them. Therefore, the research team at Jefferson tries to trick the body's immune response into thinking that the tumor cells, taken from the patient, really are foreign.

The team has demonstrated that if cyclophosphamide is given in a moderate dose, immune responses can be achieved to materials that normally elicit only weak responses. The team also uses dinitrophenyl (DNP), a hapten.

DNP is painted on the patient's skin, continuing until he or she develops a large red blotch, evidence that the body has mounted an immune response to it. When the scientists are assured that the patient will mount an immune response to DNP, it is linked with the patient's deactivated tumor cells, and the vaccine is injected. Although the body does not view the cancer cells as very foreign, it does perceive the DNP linked to them as foreign, and therefore can respond to the cells.

In reaction to this method of vaccination, fourteen of twenty-four patients showed an evident clinical response by developing an inflammatory area around the tumors, indicating that their bodies were trying to reject the tumors. This immune response was confirmed by microscopically identifying immune-type cells on biopsy specimens taken from the inflamed tumors.

Of the remaining ten patients, the tumors of seven were biopsied—and these seven did show microscopic evidence of tumor inflammation, suggesting that a more modest response was present. Thus, twenty-one of twenty-four patients mounted some type of immune activity in response to the vaccine.

In five patients, the development of tumor-inflammatory responses was followed by an actual shrinkage of the tumors. In two patients, the inflamed tumors remained unchanged in size. In seventeen patients, there was progressive tumor growth with the persistence of inflammation. Dr. Berd feels that "the shrinkage of tumors witnessed in five of the cases represents a definite advance, because the vaccine has visibly affected those tumors."

The interaction space on the second floor opens to a balcony overlooking the plaza.

the center has no windows onto the outside, it has doors and windows onto the sundrenched corridors, providing the labs with light and views of the outside. The panoramic vista from the upper stories is a wonderful relief from the minute particles studied in molecular biology. Two stairwells at opposite corners of the building have walls of windows, encouraging the occupants to use them rather than the elevators for trips between adjacent floors.

The building is turned outward, not inward as Alumni Hall is. On the lab floors of Alumni Hall, the corridors have walls of glass looking into the serene enclosed courtyards, whereas the halls of the Bluemle Life Sciences Building look out across the city.

Labs on the north and south ends have relatively narrow view windows topped with much wider transoms: the narrowness of the view window minimizes the interruption to the wall space, which is needed for cabinets, while the transom admits a wide shaft of light above the top of the cabinets. The light through the high-set transom falls deeper into the room than the light from the view window, giving brightness to the inside corners of the large rooms as well as close to the window.

In the corridors, the upper two feet of the walls near the ceilings are painted very pale tan on the odd-numbered floors and powder blue on the even-numbered. This is coordinated with the color of the cabinets in the labs, which alternate from floor to floor between light tan and medium light blue. These color changes provide a sense of which floor one is on among the many similar floors. The tan is the more successful color choice; it echoes the tan stucco ornament of the exterior and continues the warm color scheme.

The most striking element of the facade is the piano curve on the left side running from the third floor to the roof, echoed on the right side by a mirror image of the curve on the second floor only; and within these curves are the most inspired interior spaces. The shape of these lounges divides into two areas—one furnished with low chairs, the other with a long table and straight chairs—allowing different kinds of informal interaction. The windows in these spaces face the other research building, Alumni Hall. On the second floor, the lounge opens via walls of glass to the seminar room and to an exterior balcony overlooking the plaza. Again, the inside is connected to the world outside.

Pleasant to work in while highly functional, the Bluemle Life Sciences Building is truly a home for research. □

DEAN GONNELLA, FROM PAGE 27

Rodgers, M.D. '57, Associate Dean for Affiliations and Residency Programs, noted that until very recently he also took turns as an attending physician in the Hospital, where he had direct contact with students and residents at the bedside. He would demonstrate the economics of medicine by insisting that the students and residents justify each test to keep costs as low as possible while at the same time providing excellent care to the patient.

Kimitaka Kaga, M.D., Associate Professor in the Department of Otololaryngology at Teikyo University School of Medicine, made a special journey to Philadelphia for the portrait presentation. Dr. Kaga had participated in the Overseas Scholar Exchange Program of Jefferson's Center for Research in Medical Education and Health Care for six months in 1983. He noted with a smile that "There were many subjects to learn, like psychology, education, and statistics. It was as if I had chosen another career in addition to medicine—that of an educator—and was undergoing brainwashing in another country with a different ideology." However, he commented that from his experiences at the Center he formulated new strategies which are reflected in his activities today. He expressed special appreciation for the continuing exchange program which Dr. Gonnella has fostered.

University President Paul C. Brucker, M.D. accepted the portrait on behalf of the faculty, reflecting upon his long friendship with Dr. Gonnella and adding, "The nicest part about it is that we're going to have Joe around Jefferson for many years." James W. Stratton, Chairman, accepted for the Board of Trustees.

With characteristic modesty, Dr. Gonnella's response to the presentation turned the credit to others—his family first, especially his wife, Linda, and his mother, Maria Gonnella—and to the faculty and the Board of Trustees. He asked the rhetorical question, "What has been my contribution? What makes people successful? I believe they bring to a situation four things: a certain amount of intelligence; a willingness to work hard; an element of compulsiveness; and a quality you all have, a degree of dissatisfaction. You really don't want to believe what the external world tells you about your performance. Your internal voice tells you otherwise: you really could do even better!" —*C.J.T.C.*

"Health Care: A Right or a Privilege?"

A symposium on ethics, "Health Care: A Right or a Privilege?," was sponsored by Jefferson on April 6. Arguing that health care in the United States should be rationed was Daniel Callahan, Ph.D., Director of the Hastings Center, a research and educational organization that examines ethical issues of medicine and biology. On the con side was Edmund D. Pellegrino, M.D., Director of the Center for the Advanced Study of Ethics, and John Carroll Professor of Medicine and Medical Humanities, at Georgetown University. Moderating the symposium was Robert A. Burt, Esq., Southmayd Professor of Law at Yale University.

Both speakers stressed the need to find a common ground between their opposing viewpoints.

Dr. Callahan provided a historical context by pointing out that following World War II, seemingly unlimited funds were spent in the U.S. on biomedical research and clinical applications. Now, this country is entering a new phase in which we have not learned how to manage costs, and there is inequity—millions have poor care and no insurance.

When resources were seen as unlimited, the country set no priorities, and "went in all directions at once." There was no thinking about what the country's health system ought to provide.

Realizing that we must live within limits, we consider rationing, or "organized, planned, purposeful limiting of care." A society cannot spend all its resources on health care, because it has other needs such as education and transportation. "Every other country's health care system," he said, features centralized planning. Dr. Callahan described the current system in the U.S. as an uncoordinated mixture of private and federal programs, of entitlements and paying out of pocket—which he feels leads to inefficiency.

The goal of an ideal centralized system, he said, would be for every individual to have a good portion of the care he or she needs: at least access to a physician and to emergency care. "Every other developed country except South Africa has universal care," he stated. Balancings have to be made: between cure and care (nursing in the face of aging or disability), between length of life and quality of life, and between public and individual health. He stated that balance can only be achieved through rationing.

Dr. Callahan called for a better balance between length of life and quality of life, criticizing some grant-making by the National Institutes of Health that reflects an interest in longevity.

Similarly, public health—the health of a society—should be balanced with that of individuals. How much health does the group as a whole need in order to function well? Examples are immunizations for the populace, and solutions to social conditions, like poverty, that contribute to illness.

Since the late sixties, he stated, there has been a series of cost containment efforts that have not worked, and health care for the poor is getting worse. As it is, we have a lot of de facto rationing. Dr. Callahan claimed that intentional rationing—controlling prices and allocation of resources—is needed to achieve cost containment.

Dr. Pellegrino then took the podium, asserting that "rationing is not intrinsically evil, but it would be unjust in this country, at this time, and should be avoided if at all possible."

Rationing is only ethical, he feels, if we face a true economic crisis (which Dr. Pellegrino says we do not), and if we have exhausted other methods, such as practicing "effective" medicine, achieving administrative efficiency, educating patients, and using living wills (Dr. Pellegrino says we have not exhausted such solutions). Additionally, rationing is only moral if the physician is not the "gatekeeper," and if there is some forum for public opinion, as well as explicit statements of the criteria for rationing and the principles of distribution (age, merit, ability to pay, or whatever the society chooses).

Dr. Pellegrino stated that we do not as a country practice effective medicine. Many unnecessary procedures are performed. There is too much administrative overhead—too much staff, paperwork, and supervision. And the health care team itself should be streamlined; it typically has too many people, with duties too fragmented. The system of remuneration and the malpractice system need to be reformed. And "useless care" should not be provided for hopeless cases.

As alternatives to rationing, he proposes standard fee schedules, prohibition of treatments that have been shown to be ineffective, and pro bono work.

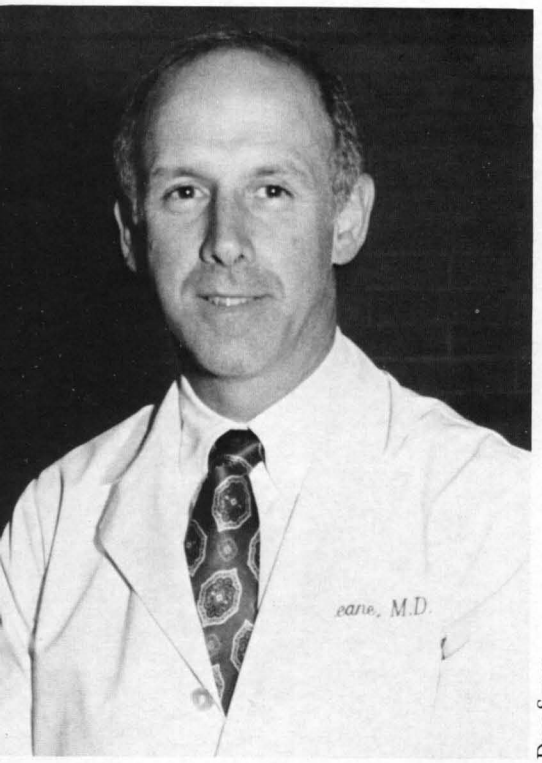
Dr. Pellegrino pointed out that rationing is distasteful to the American character because it implies a usurpation of autonomy. He asked, "Is it morally defensible for any group to make a decision without consulting the individual affected?"

After each speaker had made his presentation, Mr. Burt pointed out that a central question is how the physician, with tremendous technology at his disposal, can be motivated to avoid unnecessary or excessive expenditure. Can individuals—doctors or patients—see from the perspective of the society?

Individuals' and groups' interests and rights necessarily overlap and impinge on each other in a society, Mr. Burt commented. The American striving for self-determination must always be tempered. But are we ready for centralized planning?

—M.C.

On Campus



Dave Super

NEWLY APPOINTED AS PROFESSOR AND CHAIRMAN OF OTOLARYNGOLOGY is William M. Keane, M.D. Dr. Keane was previously a Clinical Associate Professor in Otolaryngology at the University of Pennsylvania. A graduate of Harvard Medical School, he served an internship and residency in surgery at Strong Memorial Hospital in Rochester, New York. After a residency in otolaryngology at the University of Pennsylvania, he was appointed a Clinical Assistant Professor in Otolaryngology there.

Dr. Keane has published more than forty original papers. President of the Professional Staff of Pennsylvania Hospital, he is also on the attending staff at Wills Eye Hospital, and is President-Elect of the Philadelphia Society of Facial Plastic Surgeons.

A past chairman of the Home Study Task Force in Plastic and Reconstructive Surgery of the American Academy of Otolaryngology—Head and Neck Surgery, he has received a Certificate of Honor from that organization acknowledging his contributions to its educational programs, which include serving on its Continuing Education Faculty since 1980. Among his contributions to the American Academy of Facial Plastic and Reconstructive Surgery is membership in its Task Force and Committee for Development of the Board Certification Examination. He is on the Board of Directors of Independence HMO.

Dr. Keane and his wife, Louise, have three sons.

A VISITING STUDENT PROGRAM was put together last summer by Robert S. Blacklow, M.D., Senior Associate Dean, and Mark R. Denison, M.D., Assistant Professor of Pediatrics. It was tailored to meet the interests of Karen Vartanian and Katya Smyslova, a male and female student, respectively, from two of Moscow's medical schools. The initial impetus for the program came when David M. Macfadyen, M.D., Visiting Professor of Family Medicine, was serving as Associate Dean for Health Policy while on a two-year leave of absence from the World Health Organization.

Each student chose the same broad areas of interest: high technology and family practice. They got a firsthand look at the technology involved in CAT scans and MRI's, and an overview of a high-tech health care environment. In addition, the two students rotated in two-week segments through the Office of Health Policy and Clinical Outcomes to gain exposure to policy issues, through the Office of Academic Computing to see how computers and education interact, and through the Department of Family Medicine to gain insights into Jefferson's approach to family medicine.

"The Russian medical education system is different than ours," explains Dr. Blacklow. "It's more like the English and European systems where students go directly to medical school after high school.

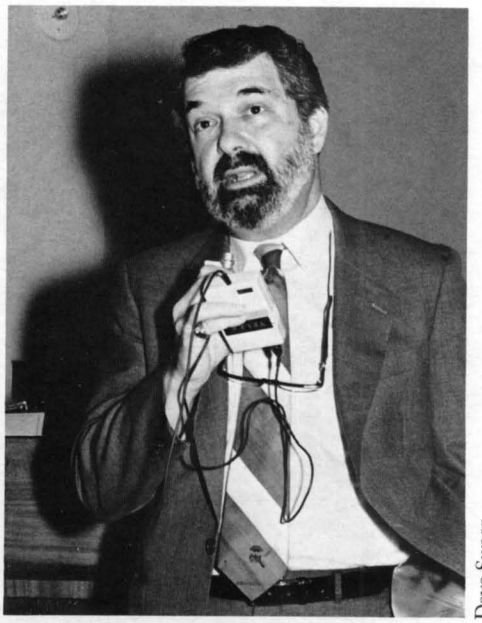
"Karen's and Katya's visit was handled in the spirit of student exchange, with Jefferson students providing housing during the week and students' families hosting them at their homes on weekends. They visited New York, Washington, and the Jersey shore, took in a Phillies game, and sampled Philadelphia jazz."

Gregory B. DiRusso, a student in the Class of '91, had helped establish the exchange program between Jefferson and the Soviet Union.

Four other Soviet students were visiting the University of Pennsylvania at the same time, so the six students participated jointly in some activities and programs.

—Adapted from *JeffNEWS*, May 13, 1991.

AN HOUR-LONG TV SPECIAL ON *CATARACT SURGERY* featured the work of Clinical Associate Professor of Ophthalmology Raymond E. Adams, M.D. One hundred forty stations across the country carried the live broadcast May 1 of an operation at Jefferson affiliate Wills Eye Hospital to remove a cataract from a fifty-year-old woman's eye. A TV camera was mounted in the operating room's microscope, so that viewers saw the patient's eye as Dr. Adams did. He used a vibrating instrument to break the cataract into minute particles, suctioned them out, and inserted an artificial lens in place of the natural one. During the broadcast, Dr. Adams explained the procedure for viewers. After the one-hour segment, a half-hour follow-up program was aired. A companion broadcast on a local FM radio station examined issues related to the operation and took phone calls from the audience.



Dave Super

Harvey M. Tucker, M.D. '64 spoke on "Surgical Voice Adjustment" in the **Clerf Lecture** on June 14. He stated that "now there is a full menu of possible remedies that didn't exist ten years ago," and he expects that within his lifetime, almost any problems—even cosmetic concerns—will be correctable.

Dr. Tucker chairs the Department of Otolaryngology and Communicative Disorders at the Cleveland Clinic, and is on the Board of Editors of the *Annals of Otology, Rhinology & Laryngology.* Dr. Tucker served his residencies in surgery and otolaryngology at Jefferson.

THE PATHOLOGY OF THE AGING HUMAN NERVOUS SYSTEM was recently authored by Serge W. Duckett, M.D., Ph.D., Professor of Neurology and Director of the Division of Neuropathology. Published by Lea & Febiger, the book reviews the pathology of neurological diseases afflicting humans over sixty-five.

Don Walker

Mark D. Brown, M.D. '65, Ph.D. '69 received this year's Distinguished Alumnus Award of Jefferson's College of Graduate Studies. In conjunction with the award, Dr. Brown lectured on May 9 on "The Pathophysiology of Lower Back Pain and Sciatica."

Chairman of the Department of Orthopaedics and Rehabilitation at the University of Miami, and a Professor of Neurological Surgery there, Dr. Brown is a national expert on diseases of the spine, and treatment of spinal disorders by surgical modalities and enzyme injections. He is an Associate Editor of *Clinical Orthopaedics and Related Research* and a member of the Editorial Board of *Spine*. He completed his residency in orthopaedic surgery at Jefferson.

"MEANDERS IN THE MOLECULAR MECHANISMS OF SKIN DISEASE" was the topic chosen by Lowell A. Goldsmith, M.D. when he delivered the **Luscombe Lecture** on April 17. Dr. Goldsmith is the Sterner Professor and Chairman of Dermatology at the University of Rochester.

A GRANT of $100,000 and a total pledge of $500,000 has been made to Jefferson by the Noguchi Medical Research Institute of Tokyo and Philadelphia, to promote medical exchange between Jefferson and Japan. The exchange will involve researchers, practicing physicians, and students.

The twenty-third annual **JEFFERSON ART EXHIBIT,** held May 9 through 22, was chaired by Elizabeth J. Zeleznik, and featured stained glass work by Karen Murtaugh.

Gerald J. Marks, M.D. '49, Professor of Surgery and Director of the Division of Colorectal Surgery, has been named "Man of the Year" by the Jewish National Fund, Physicians and Surgeons Division. In November, the Fund will undertake an afforestation project in Israel in Dr. Marks's name.

Professor of Ophthalmology **Robert D. Reinecke, M.D.** is serving as President of the Pennsylvania Academy of Ophthalmology, while **George L. Spaeth, M.D.,** Professor of Ophthalmology, is serving as Editor of *Ophthalmic Surgery,* and President of the Council of the Pennsylvania Academy of Ophthalmology, and has been appointed to the Board of Governors of the American College of Surgeons.

Earl J. Spangenberg

Jefferson Medical College Celebrates Joan Schott's Thirty Years

"I can't believe you remember my name!" How frequently that is spoken by surprised alumni as they return to Jefferson and are readily greeted by Joan E. Schott, who knows graduates from their student days.

The University officially celebrated Joan Schott's thirty years of service this spring, although she actually came to Jefferson in August 1960. She has witnessed the expansion of the Alumni Office from a small cubicle in the College to larger quarters in Alumni Hall, and has worked with three directors: Mrs. Joseph J. Mulone, Nancy S. Groseclose, and Mary B. Monteith. The combined length of service of the rest of the Alumni Office staff is only slightly greater than Joan's. She has a tremendous sense of the history of the Alumni Association. The Association is grateful for her sustained efforts and talents, and made her an Honorary Member in 1985.

Annual giving has always been Joan Schott's forte. Fond of numbers, she likes to see the annual campaigns grow. And grow they do—more than tenfold in the time she has been here. She likes to work with people to meet deadlines, and says Jefferson Medical College's success is due to its very active class agents and excellent volunteer leadership.

Today, Joan Schott is the Associate Director for Annual Giving. The Jeff Watch security committee, Safety Observers, Jefferson's United Way drive, and the First Aides hostessing volunteers have all benefited from her participation. She serves on the Franklin Forum Program Committee and the National Philanthropy Day Committee for the Philadelphia Chapter of the National Society of Fund-Raising Executives, of which she has recently become a member. In fact, she has completed course work offered by the Society. She also is active in fund-raising for her alma mater, Little Flower High School.

Joan and her husband Jack are avid fans of the Philadelphia Flyers and Eagles, and enjoy travel. Their son Kenneth is married and is a sportswriter. □

Class Notes

'20

Louis F. Burkley, Jr., Moravian Hall Square, 175 W. North St., Nazareth, PA 18064, would like to hear from other members of his class.

'30

Joseph F. Ricchiuti, 1702 Mahantongo St., Pottsville, PA 17901, spends the winter months in Boca Raton, Florida. He golfs, and paints in oils and watercolors.

'32 Reunion Class

C. Earl Albrecht, 4415 Muirfield Dr., Highland Lakes, Bradenton, FL 34210, was honored in July at a reception introducing the Albrecht-Milan Foundation of the American Society for Circumpolar Health. The reception was held at the University of Alaska at Anchorage. The Society seeks to increase awareness of the unique health care needs of the world's polar region.

James J. Grace, 27 S. Main St., Montrose, PA 18801, retired in June.

'36

Albert W. Freeman, 76 W. King St., Shippensburg, PA 17257, is still in active practice.

'37 Reunion Class

Bernard B. Zamostien, 139 Colwyn Ln., Bala Cynwyd, PA 19004, has been named Family Physician of the Year by the Pennsylvania Academy of Family Physicians.

'39

Hymen D. Stein, 206 Hill House, 1680 Huntingdon Pike, Huntingdon Valley, PA 19006, was honored in April at a reception at Centennial Spring Health Care Center, where he served as Medical Director for eight years.

'41

Paul H. Pettit, 1010 Kings Row, Lake Suzy, FL 33821, has received the Golden Merit Award for fifty years in medicine from the Medical Society of New Jersey.

'43

John N. Lindquist, 422 Sabine Rd., Wynnewood, PA 19096, has been named to the Board of Directors of the Philadelphia Senior Center for a three-year term.

David E. Schlosser, 2226 Milton Grove Rd., Mount Joy, PA 17552, has been busy with woodworking, reading, playing tennis and duplicate tournament bridge, and substituting as church organist.

'46

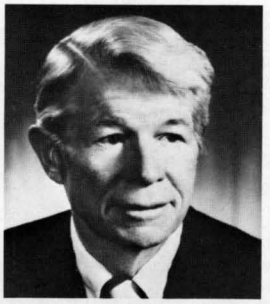
Harold H. Alderfer, 220 E. Ashbridge St., West Chester, PA 19380, has retired.

Seymour Krevsky, 630 N. Woodward Ln., Birmingham, MI 48009, is still actively pursuing pediatric and adolescent practice. In recent summers he has worked at Indian Health Services.

'47 Reunion Class

Gerald D. Dodd, Diagnostic Radiology, M. D. Anderson Cancer Center, Houston, TX 77025, received an honorary degree of Doctor of Science from Lafayette College in June.

James T. Helsper, 50 Bellefontaine St., Pasadena, CA 91105, was honored in May at the Daffodil Ball held by the San Gabriel/Pomona Valleys Unit of the California Division of the American Cancer Society. He was recognized for his many years of volunteer contributions. Dr. Helsper is an Associate Clinical Professor of Surgery at the University of Southern California School of Medicine, and Chief of Surgical Oncology Teaching Services at Huntington Memorial Hospital.



'48

Robert K. Finley, Jr., 30 Apple St., Dayton, OH 45409, has been appointed a Professor of Surgery at Wright State University.

Robert S. Lackey, 2118 Pinewood Cir., Charlotte, NC 28211, has retired from active practice of radiology after thirty-five years.

'49

John G. Finley, 440 Lawrence Rd., Huntingdon Valley, PA 19006, is working full-time in radiology at St. Mary Hospital in Langhorne.

Stuart W. Hamburger, 27440 Lake Hills Dr., Franklin, MI 48025, retired in July as Chairman of the Department of Surgery at Sinai Hospital in Detroit, though he will continue on its staff as Chairman Emeritus and Consultant in Surgery. He is "now embarking on a new career as grandfather and professional fisherman."

Dr. Hamburger is eager to stay in touch with Jefferson. He currently serves as Alumni Vice-President for the State of Michigan.

Edward J. Saltzman, 3501 N. Keyser Ave., Villa 38, Hollywood, FL 33021, has retired from active pediatric practice, but continues to devote much of his time to national pediatrics organizations.

Robert E. T. Stark, 444 W. Osborn Rd., Suite 102, Phoenix, AZ 85013, wrote an article on "Obesity" for the 1992 edition of *Conn's Current Therapy,* published by Saunders (Philadelphia).

'51

Philip J. Escoll, 431 Hidden River Rd., Penn Valley, PA 19072, received the 1991 Robert Dunning Dripps Memorial Award for excellence in graduate medical education at the University of Pennsylvania.

H. Edward LaVoice, Jr., 900 Warwick Rd., Haddonfield, NJ 08033, is working part-time as an independent consultant in occupational medicine, for workmen's compensation permanent disability evaluations.

'52 Reunion Class

Joseph H. Sloss, 7814 Seville Cir. West, Bradenton, FL 34209, began serving as Vice-President for Medical Affairs at Manatee Memorial Hospital in Bradenton in July. Dr. Sloss has been awarded membership in the American College of Physician Executives.

'53

Lansing H. Bennett, American Consulate General Rio, APO Miami, Fl 34030, writes, "still wandering over the whole of South America from Guiana to Argentina for the U.S. government. Will end my world travels this fall and return to the Washington, D.C. area—hope to spend lots of weekends sailing."

Harold W. Rushton, 327 Knoll Top Ln., Haddonfield, NJ 08033, has been serving as Chairman of the State Credentials Committee for New Jersey of the American College of Surgeons.

'54

Rudolph C. Camishion, 1101 Cherry Ln., Riverton, NJ 08077, has received the 1991 Shaffrey Award from the Medical Alumni of Saint Joseph's University.

Robert A. Hinrichs, 2007 Galatea Terr., Corona Del Mar, CA 92625, recently saw **Murray N. Silverstein,** 5911 11th Ave. SW, Rochester, MN 55901, who was in California to give a lecture.

Service in Liberia

by Paul G. Brenneman, '48

Liberia is an enigma. It has been devastated by a civil war. Why should a country that has been a democratic republic since 1847 be torn apart by party strife, hatred, confusion, and tribalism?

The United States played a key role since the nineteenth century in developing Liberia to the highest standard of living of any West African country. It even had a medical school as part of the university. Its capital, Monrovia, had been named for President Monroe of the United States, for it was during his administration that freed slaves returned to Africa to establish Liberia, so called for their new-found liberty.

Beginning on Christmas Eve 1989, and lasting most of the following year, the country was devastated by warring parties. A third of the population fled to neighboring countries.

The civil war was ignited by the collective resolve of the people to rid their country of the suffering occasioned by corruption, greed, and nepotism under the administration of President Samuel K. Doe. Now, many months after Doe's death, people are still going without enough food, and medical facilities lie in ruin. There are no government services such as postal or telephone, and only sporadic electric power. An editorial in a newspaper states, "The crisis is being prolonged because it would appear, despite our public pronouncements, that some of us are desperately pursuing our own ambitious interests without considering the welfare of the people or fair play and justice." The only peace in effect is that provided by the military occupation by ECOMOG, a cease-fire monitoring group drawn from West African countries.

Because I am retired, the Mennonite Board of Missions recruited me for a three-month term under the Church World Services of the National Council of Churches. The medical team consisted of three doctors and two nurses, and my wife, Grace, was in charge of the affairs at our apartment during our stay.

Artillery destruction at the main entrance to the University of Liberia

Our team was assigned by the Liberian Health Committee to open the Cooper Clinic of the Seventh-Day Adventist Church. The clinic's doors had been closed by the rebel forces of Charles Taylor on September 12, 1990, when it had been broken into, looted, and left in a shambles. Twelve bodies were found in the building—supposedly sympathizers of Doe—including four killed while in hospital beds. They and the bodies of others killed on the streets over the next three months had been left to decay, and even now one sees skeletons lying around. Similar events had occurred in other health care facilities, so when we arrived in January only two hospitals, of thirty-five and fifty beds respectively, were in operation for a population of over five hundred thousand—totally inadequate.

We signed an agreement to run the clinic for six months as an outpatient facility, hoping to open an inpatient service at some later date. It took several days to clean up the litter and scrub down the clinic with disinfectant. There was enough furniture to supply four doctors' offices. We were able to recruit Liberian staff, including two doctors, two nurses, two pharmacists, two receptionists, and later an X ray technician and a laboratory technician. We officially opened the clinic on January 16 after it had been closed for just over four months.

At first the number coming into the clinic was small—twenty-six people the first day—but it wasn't long until we were seeing a hundred, and by the time I left up to two hundred daily. We had serious shortages of medical supplies, and for the first two months no laboratory. X ray became available at the end of February when we were able to get the generator running, but diesel fuel was expensive and in short supply. So essentially we were making each diagnosis from the patient's history and physical examination—bush medicine—but that was better than nothing. The people received us well and thanked us for coming so far to help them.

What illnesses did we see besides those one sees in the United States? Malnutrition was evident in about ninety percent of the patients; it was severe in about ten percent, especially young children. I saw my first cases of kwashiorkor, manifested by emaciated chests (one could count the ribs), pot bellies, and marked edema of the lower extremities. Because of their severe malnutrition these children needed wholesome food more than medication. Very little food was available for as long as three months. Unicef supplied food, and we followed their protocol, opening an intensive feeding program in the ground floor of our clinic. Five meals per day were served from eight o'clock in the morning till five in the afternoon. We could accommodate up to fifty-five children. It was most gratifying to note the improvement in their appearance in just two weeks. I made rounds each day prescribing medication for those who were ill. We lost a few of the more severely ill.

Grace Brennema

Besides malnutrition, we saw malaria in roughly thirty-five percent of children and adults. It was my first experience treating the disease. Enlarged spleens and anemia were common. There were intestinal parasites, scabies, and dysentery —amoebic and bacterial and viral. It was frustrating not to be able to provide optimum care because our drug supply was limited. Patients needing hospitalization had to be referred, but sometimes beds were not available, so we hoped the upper floor of our clinic would be opened for inpatient care sometime in the future.

We had a well-furnished apartment, but no running water, and no electricity for as long as three weeks. It is amazing how one can improvise. We felt somewhat isolated, for there were no postal or telephone services, and no commercial flights—only chartered flights provided by the United Nations. Most unpleasant was the heat, which never went below eighty-two degrees even at night.

The rewards of caring for people, with the chance to see another part of the world, and to receive the many expressions of appreciation from the patients, far exceeded the unpleasant things we encountered. It was a rich, rewarding experience, and I feel privileged and favored by the opportunity to serve in such a needy area. □

'55

Edwin D. Arsht, 3909 State Rd., Drexel Hill, PA 19026, married Susan Straff in February.

W. Taylor Brandfass, 1410 Monk Rd., Gladwyne, PA 19035, has joined the medical staff of Springfield Hospital.

John J. Hoch, 266 Hillside Ave., Nazareth, PA 18064, has been named Person of the Year by the Nazareth Area Chamber of Commerce.

Ray M. Kessel, 141 Wood Lomand St., Huntington, WV 25705, has received the 1991 Family Doc Award of the West Virginia Chapter of the American Academy of Family Physicians.

Richard H. Schwarz, 30 Waterside Plaza, 27J, NY, NY 10010, has been named President of the American College of Obstetricians and Gynecologists. Dr. Schwarz is Provost and Vice-President for Clinical Affairs at the State University of New York, Health Science Center at Brooklyn.

Dr. Schwarz has been active in combating AIDS and HIV infection in women, particularly pregnant women, and has been a prominent ACOG spokesman on these issues. He served as a member of New York City's Health Systems Agency Task Force on AIDS.

'56

John W. Holdcraft, 150 Rugby Pl., Woodbury, NJ 08096, retired in April.

Richard T. Price, 1231 N. Ridge Rd., Perkasie, PA 18944, is "still enjoying my Jeff connection —this is the fifteenth year I have served as a Senior Student Preceptor for the Family Medicine Department—a very satisfying and meaningful contribution to our alma mater."

'58

Peter Amadio, Jr., 733 Spring Valley Rd., Doylestown, PA 18901, has been named Professor of Family Medicine at Jefferson.

'59

Ronald E. Cohn, Mercy Hospital, 565 Abbott Rd., Buffalo, NY 14220, spoke at the national conference of the American College of Physician Executives in Toronto in May. Dr. Cohn presented a session on "Competition Versus Cooperation."

William E. Ryan, 116 Washington Crossing Rd., Pennington, NJ 08534, is President-Elect of the Medical Society of New Jersey.

Terrence J. Thomas, 312 Sherman St., Meyersdale, PA 15552, has been elected Chief of the Medical Staff at Meyersdale Community Hospital.

'60

Edward J. Haberern, 4205 Lehigh St., Whitehall, PA 18052, has opened a practice in Lakewood.

William F. Hushion, 120 E. Bishop Hollow Rd., Media, PA 19063, retired in May from Philadelphia Electric Company. He plans to do consulting in occupational medicine and addiction treatment.

Herbert D. Kleber, 3405 Greenway, #201, Baltimore, MD 21218, who is Deputy Director for Demand Reduction in the Office of National Drug Control Policy, writes, "I predict both a greater emphasis on treatment and prevention during the next few years, and a sharp drop in cocaine use. I expect cocaine use by 1995 to be only fifty percent of what it was in 1988."

'61

Jerry D. Harrell, 411 Whitefield Ave., St. Simons Island, GA 31522, writes, "I completed my career in the Army last year in Panama. Since then I have been working at a mission eye clinic in Mombasa, Kenya, where we do a lot of cataract and glaucoma surgery and see some unusual pathology, for example, subretinal microfilaria and keratitis due to the spitting cobra."

Stanton N. Smullens, 1710 Pine St., Phila., PA 19103, has been named a Clinical Professor of Surgery at Jefferson.

'62 Reunion Class

George P. Moses, 166 Hanover St., Suite 204, Wilkes-Barre, PA 18702, has received the Frances P. Nork Memorial Award of the Wyoming Valley Unit of the American Cancer Society. The award recognizes service to the society and the community.

'63

John M. Fenlin, 836 Bryn Mawr Ave., Narberth, PA 19072, has been promoted to Clinical Professor of Orthopaedic Surgery at Jefferson.

Manfred W. Lichtmann, 8817 Twin Creek Ct., Potomac, MD 20854, has been appointed Vice-Chairman of the Department of Anesthesiology, and Director of the Operating Room, at George Washington University Medical Center.

Books by Alumni

Paul Cutler, J'44, 21203 Lago Cir., 15A, Boca Raton, FL 33433, is working on the third edition of his textbook, *Problem Solving in Clinical Medicine.*

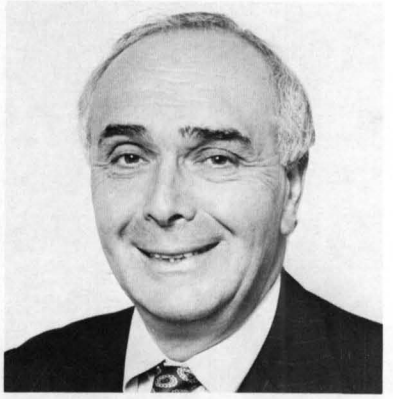
William W. L. Glenn, '38, 685 Forrest Rd., New Haven, CT 06515, has been honored by the renaming of a textbook of which he had been Senior Editor for the Fourth Edition. *Glenn's Thoracic and Cardiovascular Surgery* is now in its fifth edition; previously it was known simply as *Thoracic and Cardiovascular Surgery.* The fifth edition received a laudatory review in the June 13 *New England Journal of Medicine.* Dr. Glenn is the Charles S. Ohse Professor Emeritus and Senior Research Scientist at Yale.

Charles H. Klieman, '67, 12433 E. Lambert Blvd., Suite C, Whittier, CA 90606, has published *If It Runs in Your Family: Heart Disease—Reducing Your Risk.*

Simon Piovanetti, '51, 204 Pintor Campeche, Hato Rey, PR 00918, had his new pediatrics manual in Spanish published in June.

James R. Roberts, '72, 302 Chamounix Rd., St. Davids, PA 19087, served as Editor of the second edition of *Clinical Procedures in Emergency Medicine,* published in June by Saunders (Philadelphia).

'64



David L. Paskin, 301 S. Eighth St., Suite 3E, Phila., PA 19106-4080, has been named Chairman of the Department of Surgery at Pennsylvania Hospital, and a Clinical Professor of Surgery at the University of Pennsylvania.

Carl M. Pinsky, Frederick Cancer Res. Fac., Frederick, MD 21701, is serving as Vice-President for Medical Affairs at Immunomedics, Inc.

'67 Reunion Class

Edward M. Salgado, 2920 Center St., Bethlehem, PA 18017, has been elected to the Board of Trustees of St. Luke's Hospital.

Matthew White, 11311 Bridgeport Way SW, #304, Tacoma, WA 98499, has welcomed two new partners to his busy family medicine practice in the past two years. He "continues to enjoy being in the Pacific Northwest—backpacking, skiing, and salmon and trout fishing."

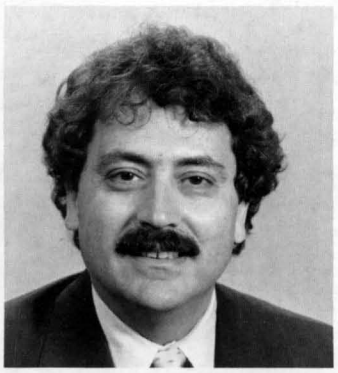
Gary L. Wolfgang, 101 N. Crestwood Dr., Danville, PA 17821, has been appointed a Clinical Professor of Orthopaedic Surgery at Jefferson (at Geisinger Medical Center).

'68

Kenneth B. Reynard, 5505 S. Krameria, Englewood, CO 80111, has been working at a new Center for Magnetic Resonance Imaging at St. Anthony Hospital in Denver.

'69

Philip H. Geetter, 711 Lawn Ave., P.O. Box 49, Sellersville, PA 18960, has been elected President of the Medical Staff at Grand View Hospital.



Jay S. Skyler, 1111 Crandon Blvd., C205, Key Biscayne, FL 33149-2733, has been elected President of the National Board of Directors of the American Diabetes Association.

'71

Cora L. E. Christian, P.O. Box 1338, Frederiksted, St. Croix, U.S. Virgin Islands 00841, continues as Assistant Commissioner of Health for Prevention, Health Promotion, and Protection in the Virgin Islands, Medical Director of the Virgin Islands Medical Institute, and President of the Virgin Islands chapter of the American Academy of Family Practice. This past January Dr. Christian coauthored an article in *Ethnicity and Disease,* published by Loyola University Stritch School of Medicine; her topic was "Prevalence of Elevated Blood Pressure in Children: Results from a United States Virgin Islands Household Survey, 1988." Dr. Christian is also the author of the Hurricane Hugo Health Assessment, which she presented to U.S. Secretary of Health and Human Services Louis W. Sullivan, M.D. in July 1990.

'72 Reunion Class

James R. Roberts, 302 Chamounix Rd., St. Davids, PA 19087, has been promoted to Professor of Emergency Medicine at the Medical College of Pennsylvania, and has been appointed Director of the Division of Toxicology.

'73

Joseph W. Sassani, 304 Candlewyck Ln., Hershey, PA 17033, is President-Elect of the Pennsylvania Academy of Ophthalmology; he will begin serving in June 1992.

Daniel M. Scotti, 720 Redman Ave., Haddonfield, NJ 08033, presented a paper on his new invention, a two-piece T-tube, at the Society of Cardiovascular and Interventional Radiology in San Francisco in February.

'74

Barbara F. Atkinson, 715 Saint George's Rd., Phila., PA 19119, has been elected a Trustee of the American Board of Pathology.

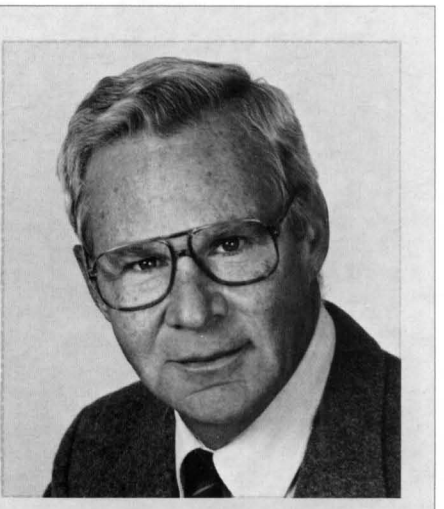
Michael H. LeWitt, 1128 Cymry Dr., Berwyn, PA 19312, has been appointed an Instructor in Medicine at Jefferson.

Allen E. Meyer, 610 Orchard Way, Lansdowne, PA 19050, has been appointed to the governing council of Fitzgerald Mercy Hospital.

Arnold J. Willis, 2011 White Oaks Dr., Alexandria, VA 22306, and his wife, Lilian, are thrilled at the birth of Andreas M. Willis. Dr. Willis, a Clinical Assistant Professor of Urology at George Washington University, is serving as Washington Regent for the International College of Surgeons.

'75

Ellis R. Levin, 620 33rd St., Manhattan Beach, CA 90266, has accepted a joint appointment in the Departments of Medicine and Pharmacology at the University of California at Irvine. Dr. Levin received the 1991 Outstanding Science Award of the Federal Executive Board of Los Angeles, for his research on the neuroendocrinology and neurobiology of vasoactive neuropeptides. The award is given to a federally funded researcher in southern or central California.



George L. Adams, '66 has been appointed Professor and Head of the Department of Otolaryngology at the University of Minnesota, having previously been Associate Head and Interim Head. Dr. Adams serves on the Executive Committee of the National Cancer Institute's Head and Neck Intergroup. He edited the two most recent editions of *Fundamentals of Otolaryngology,* published by Saunders (Philadelphia).

'76

J. Kirk Beebe, Box 786, 400 Savannah Rd., Lewes, DE 19958, has been appointed to the Delaware Board of Medical Practice by Governor Castle.

Paul B. Gilman, 321 Baintree Rd., Rosemont, PA 19010, has been named a Clinical Assistant Professor of Medicine at Jefferson.

Robert J. McCunney, 55 Eliot St., #42, Boston, MA 02130-2749, has been elected to the Board of Directors of the American College of Occupational/Environmental Medicine.

Nancy S. Roberts, 134 Cherry Ln., Wynnewood, PA 19096-1220, has been appointed to the medical staff of Paoli Memorial Hospital.

Michael E. Stillabower, 1901 Dorcas Ln., Wilmington, DE 19806-1163, has been promoted to Clinical Assistant Professor of Medicine at Jefferson (at the Medical Center of Delaware).

'77 Reunion Class

James F. Burke, 241 Brydon Rd., Wynnewood, PA 19151-1306, has been promoted to Clinical Associate Professor of Medicine at Jefferson, and **R. Anthony Carabasi III,** 818 Northwinds Dr., Bryn Mawr, PA 19010, has been promoted to Professor of Surgery.

Virginia C. Wood, 5760 Wilcke Way, Dayton, OH 45459, has received the 1991 Teaching Excellence Award of Wright State University School of Medicine.

'78

Charles B. Austin, Jr., 1102 Saffron Dr., Mechanicsburg, PA 17055, is now practicing radiology in Harrisburg.

Barbara M. Matteucci, 2226 Wallace St., Phila., PA 19130, received the Blockley-Osler Award at Hahnemann University in May for excellence in the teaching of clinical medicine. Dr. Matteucci is an Assistant Professor of Medicine in the Division of Clinical Immunology and Rheumatology.

'80

James D. Balshi, 3036 Summer Ln., Bethlehem, PA 18017, has been elected a member of the American Venous Forum, a society for research, education, and clinical investigation in diseases of the veins. Membership is limited to three hundred physicians worldwide. After completing his surgical residency at the Hospital of the University of Pennsylvania, Dr. Balshi was the Smithwick Fellow in peripheral vascular surgery at Boston University Medical Center, where he was also an Instructor in Surgery. He has received the Jobst Award for excellence in clinical research in venous diseases.

Stephen T. Bell, 1121 Oak Mont Dr., Lancaster, PA 17601, and his wife, Wendy, are thrilled at the birth of Kerri Lynne last November.

Stephen A. Geraci, P.O. Box 6595, Silver Spring, MD 20906, has been appointed a Clinical Assistant Professor of Medicine at George Washington University, in addition to being a Research Fellow in Clinical Pharmacology at the Uniformed Services University of the Health Sciences.

Shahab S. Minassian, 144 Whitemarsh Rd., Ardmore, PA 19003-1635, has been certified in reproductive endocrinology, and is directing the section of reproductive endocrinology at the Medical College of Pennsylvania.

Daniel B. Mingle, R.F.D. 1, Box 720, South Paris, ME 04281, is "always looking for another doctor to join our family practice group in Norway, Maine."

'81

Lawrence M. Correnti, 97th Gen. Hosp., Box 4, APO NY 09757-3398, and his wife, Elizabeth, are the proud parents of Caroline Emily, born January 28. "After spending nearly four years in Germany, we have traveled enough and are ready to return to the United States."

David J. Ellis, 112 Drakes Drum Dr., Bryn Mawr, PA 19010, has been appointed a Clinical Assistant Professor of Urology at Jefferson.

Robert K. Finley III, 116 Delta Rd., Eggertville, NY 14226, finished a two-year surgical oncology fellowship at Roswell Park Cancer Institute in June. He and his wife, Cathy, are thrilled at the birth of Luke William on May 30.

Anthony A. Gaspari, 91 Waterford Way, Fairport, NY 14450-9749, has been appointed an Assistant Professor of Oncology in the Cancer Center at the University of Rochester, in addition to serving as an Assistant Professor of Dermatology. Dr. Gaspari will collaborate on research on the body's immune response to skin cancers such as malignant melanoma.

With a grant from the American Cancer Society, Dr. Gaspari has researched the damaging effects of ultraviolet light on skin cells which help rally the body's defenses against infections and other agents harmful to the skin, including chemicals that cause allergic skin rashes.

In April, he received funding from the National Institutes of Health for a five-year study of how the immune system naturally turns off during allergic skin responses. Understanding how the immune system modulates its responses, he believes, may provide clues about why the system fails to respond to some cancers.

Before joining the University of Rochester, Dr. Gaspari completed a four-year fellowship at the National Cancer Institute's Dermatology Branch.

Stuart L. Gordon, 619 College Ave., Haverford, PA 19041, has been elected to Fellowship in the College of Physicians of Philadelphia.

Kevin A. Mansmann, 1004 Garrett Mill Rd., Newtown Square, PA 19073, and his wife are the proud parents of Ryan Taylor Mansmann, now one year old.

Victor G. Onufrey, 1901 Teal Trace, Pittsburgh, PA 15237-3827, has joined a private radiation oncology practice at West Penn Hospital.

Andrej J. Zajac, 512 Northern Spy Rd., Clarks Summit, PA 18411, spoke at a symposium on "Brachytherapy: Past, Present, and Future" in Scottsdale, Arizona in May.

'82 Reunion Class

Alex V. Levin, 3329 W. Penn St., Phila., PA 19129, has been appointed an Instructor in Ophthalmology at Jefferson.

Judd W. Moul, 9121 Town Gate Ln., Bethesda, MD 20817, is studying the molecular biology of testicular cancer at the Uniformed Services University of the Health Sciences, with a grant from the University and the H. M. Jackson Foundation.

Gregory T. Smith, 5C Springwood Sq., Harwick, PA 15049, has joined a group practice of cardiology.

'83

Thomas A. Cacciola, 403 Farview Ave., Paramus, NJ 07652, and his wife, Susan, are the proud parents of Catherine Ann, now one year old.

Barbara Lea Davies, 3215 Shrine Rd., #8, Brunswick, GA 31520, has entered the private practice of plastic and reconstructive surgery. She insists, "'Y'all come down now, y'hear?!'"

Glenn A. Mackin, 289 Marlborough St., #13, Boston, MA 02116, is moving back to Philadelphia to begin a second two-year clinical research fellowship, in neuromuscular diseases and electrophysiology, at the Hospital of the University of Pennsylvania.

Philip M. Maurer, 631 Addison St., Phila., PA 19147, has been appointed an Instructor in Anesthesiology at Jefferson.

Elizabeth C. Squiers, 30 Overlook Dr., Danville, PA 17821-9616, has been appointed an Assistant Professor of Surgery at Jefferson (at Geisinger Medical Center).

'84

John F. Cox, 7926 Blossom Heights, Fogelsville, PA 18051, is a diagnostic radiologist at Lehigh Valley Hospital Center.

Peter A. DeMaria, Jr., 2 Armstrong Cir., Newtown, PA 18940, has been board certified in psychiatry, and certified in addiction medicine by the American Society of Addiction Medicine. He continues as Medical Director

of the methadone program at Jefferson. His wife, **Gail Reedman DeMaria,** has a flourishing practice. They keep in touch with **Joseph M. DellaCroce,** 46 Trumbull Ct., Newtown, PA 18940, and **Gregory R. Gordon,** 1355 Apple Blossom Dr., Yardley, PA 19067.

Maribeth DiNicola Sullivan, 65 Moulton Ridge Rd., Kensington, NH 03833, is practicing obstetrics and gynecology in Exeter. She and her husband, Neil, have a one-year-old daughter.

Robert F. Early, Jr., 1800 Bern St., Reading, PA 19604, and his wife, Michele, are the proud parents of Rachel Elizabeth, now one year old.

Louis A. Kazal, Jr., 5510 Greenbriar Dr., Houston, TX 77005, has been appointed an Assistant Professor of Family Medicine at Baylor College of Medicine. He and his wife, Rebecca, are thrilled at the birth of Hannah Rebecca on April 29.

Herman J. Michael, 300B Saybrook Ln., Wallingford, PA 19086, has been promoted to Clinical Assistant Professor of Medicine.

Suresh G. Nair, 2 Rich Ln., Elysburg, PA 17824, has joined the Geisinger Clinic in hematology and oncology.

John C. Oberholtzer, 2300 Naudain St., Apt. F, Phila., PA 19146, has been appointed an Assistant Professor of Pathology and Laboratory Medicine (Neuropathology) at the University of Pennsylvania.

Robert D. Wallace, 200 Wagner Pl., #904, Memphis, TN 38103, began a residency in plastic and reconstructive surgery in June at the University of Tennessee, Memphis Medical Center.

'85

John A. Martin, Jr., 409 N. Narberth Ave., Narberth, PA 19072, has joined the orthopaedic surgery staff of St. Joseph Hospital in Reading, where he will also serve as Medical Director of the sports medicine program.

'86

Janice H. Dickter, 128 Beechwood Dr., Newtown Square, PA 19073, has joined the pediatrics department at Phoenixville Hospital.

Kent E. Kester, 2650 Thousand Oaks Dr., #1501, San Antonio, TX 78232, and his wife, Mary Beth, are the proud parents of Sarah Elizabeth, who was born May 16. Dr. Kester is a staff physician in the General Medicine Department at Brooke Army Medical Center at Fort Sam Houston.

Bernard L. Lopez, 115 Croton Rd., Wayne, PA 19087, has been appointed an Instructor in Surgery (Emergency Medicine) at Jefferson. Dr. Lopez and his wife, Tina, had their first child, Gregory James, in February.

Paul J. Lynott, Spring Ridge Apts., Whitehall, PA 18052, has joined Northampton Medical Associates.

Suzanne F. Matunis, 6791 Walnut Creek Dr., Fairview, PA 16415, has joined Elk Valley Medical Center in Girard.

Michael J. O'Donnell, 2241 Baffin Bay Dr., Corpus Christi, TX 78418, is moving to Iowa to begin a dermatology residency at the University of Iowa.

Rosalie Pepe, 724A Sutton Towers, Collingswood, NJ 08107, is practicing at Graduate Hospital.

John A. Snell, 7605 Tortola Bay Ln., Las Vegas, NV 89128, served in an Air Force hospital in the Persian Gulf last winter.

Stephen F. Wawrose and **Sarah E. Kohl,** 196 Newton St., San Francisco, CA 94112, are the proud parents of Ann Marie Wawrose, who is now one year old. They would welcome visitors to the Bay area.

'87 Reunion Class

Steven A. Maser, 201 S. 18th St., #820, Phila., PA 19103, married Kara Beth Weiss on February 23 in Livingston, New Jersey. Dr. Maser will begin a hand fellowship at Jefferson in July 1992.

John F. Wilson, 2464 Brentwood Rd., Union, NJ 07083, and his wife, Deanna, are delighted at the birth of Alexandra Margaret Shaw Wilson on May 23.

'88

Evaline A. Alessandrini, 1409-1 E. Abingdon Dr., Alexandria, VA 22314, will serve as Chief Resident at Children's National Medical Center in Washington, D.C. for 1991-92, while **Patricia M. Curtin,** 2101 N. Franklin St., Wilmington, DE 19802, will serve as Chief Resident in Internal Medicine at the Medical Center of Delaware.

Laurie A. Karl, 710 Green Grove Rd., Neptune, NJ 07753-2904, married Donald Chislow on March 17.

Stacia T. Remsburg, 1480 Commonwealth Ave., Suite 4, Brighton, MA 02135, has begun a fellowship in pulmonary critical care at Brigham and Women's Hospital in Boston.

Randall V. Wong, 4412 Garrison St. NW, Washington, DC 20016, and his wife, Tamae, are the proud parents of Marina Maeda Wong, who was born last November.

'89

Christopher B. Furlong, 3853 Ingraham St., C203, San Diego, CA 92109, is Medical Officer for the USS *Rushmore*.

Obituaries

John D. Sturgeon, Jr., '20 died February 9. A resident of Uniontown, Pennsylvania, Dr. Sturgeon had practiced pediatrics.

Edgar H. Weber, '22 died April 30, 1990 at age ninety-one. Dr. Weber had lived in Evansville, Indiana.

Samuel S. Shapiro, '24 died June 3, 1991 at age ninety-two. Dr. Shapiro had practiced family medicine in Philadelphia for fifty-two years. He was affiliated with St. Luke's Hospital and Stetson Hospital, of which he became Chief of Staff. He is survived by a son, **Bertram H., '56.**

James H. Tate, '26 died April 11 at age eighty-nine. Dr. Tate had practiced family medicine for more than forty years in Erie, Pennsylvania, and had served as President of the Medical Staff at Hamot Hospital. He is survived by his wife, Helen, of 14560 Lakeside Cir., #222, Sterling Heights, MI 48078, a daughter, and two sons.

W. Gifford Crothers, '27 died May 20 at age eighty-eight. Named Chief of the Orthopaedic Department at the old Chester Hospital (now part of Crozer-Chester Medical Center) in 1946, Dr. Crothers organized the first fracture service there and helped to organize the Department of Physical Medicine. He became President of the Medical Staff in 1960. Dr. Crothers was a former President of the Delaware County Medical Society, and a Fellow of the American College of Surgeons. Survivors include his wife, Sara, of P.O. Box 1516, Media, PA 19063, two daughters, and a son.

Alfred W. Dubbs, '31 died December 30 at age eighty-five. Dr. Dubbs had practiced cardiology in Allentown, Pennsylvania, serving as Chief of Medicine at Sacred Heart Hospital.

Charles F. Hawley, '32 died March 23. Dr. Hawley had practiced family medicine in Binghamton, New York.

Thomas W. Kredel, '32 died December 25 at age eighty-two. Dr. Kredel was a general practitioner in Ligonier, Pennsylvania.

Jacob Lichstein, '32 died March 1. An Emeritus Associate Clinical Professor of Medicine at the University of California

at Los Angeles, Dr. Lichstein was a past President of the Southern California Society of Gastroenterology, and a Fellow of the Menninger Foundation. After retiring, he devoted his time to medical and nonmedical writing, and raising almonds on his ranch. He worked two summers in London at the British Museum.

Clarke M. Forcey, '35 died January 17 at age eighty-one. Dr. Forcey had practiced radiology in Philipsburg, Pennsylvania.

William M. Bush, '37 died January 14 at age seventy-seven. Dr. Bush had practiced obstetrics and gynecology in Reading, Pennsylvania.

C. Roger Kurtz, '39 died May 30 at age seventy-seven. Dr. Kurtz was a past President of the American Cancer Society's District of Columbia Division, and a member of its national board. In 1965, he received the national organization's St. George Medal. Dr. Kurtz maintained a general practice in Washington for more than three decades. He is survived by his wife, Mary, of 15400 Bassett Ln., 3D, Silver Spring, MD 20906.

R. Edward Steele, '39 died April 21 at age seventy-eight. Dr. Steele had practiced in Harrisburg for thirty-five years, serving as chief of the medical staffs at Holy Spirit Hospital and Harrisburg Hospital. He was a Clinical Professor of Surgery at Hahnemann University and The Pennsylvania State University, a Fellow of the American College of Surgeons, a past President of the Dauphin County Medical Society, and a member of the President's Club at Jefferson. Survivors include his wife, Helen, of 3610 Logan St., Camp Hill, PA 17011-2737, two daughters, and a son.

Glenn L. Williams, '39 died May 18 at age seventy-nine. Dr. Williams had practiced obstetrics and gynecology in the Germantown section of Philadelphia. He is survived by a daughter.

Thomas H. Aughinbaugh, Jr., '40 died January 30 at age seventy-six. Dr. Aughinbaugh had specialized in emergency medicine.

Earl W. Schafer, Jr., '41 died March 28. Dr. Schafer was an orthopaedic surgeon. He is survived by his wife, Margaret, of 105 Shadow Valley Rd., High Point, NC 27262.

William L. Goodin, '43 died April 10. A resident of California at the time of his death, Dr. Goodin had practiced internal medicine and rheumatology in Tucson, Arizona.

John R. Wakefield, '45 died June 10, 1989, the Alumni Office recently learned. Dr. Wakefield had practiced internal medicine in Georgia. He is survived by his wife, of 205 Berkshire Way, Marlton, NJ 08053.

John L. Redmond, Jr., '46 died April 2, 1991. Dr. Redmond had served as Pathologist and Chief of Laboratories at Phelps Memorial Hospital in Tarrytown, New York.

John D. Groblewski, '47 died February 28 at age sixty-eight. Dr. Groblewski had practiced general surgery in Kingston, Pennsylvania.

Harold B. Cooper, '52 died April 22 at age sixty-five. A family practitioner, Dr. Cooper had served as President of the Schuylkill County Medical Society, and as a board member of Good Samaritan Regional Medical Center, Pottsville Hospital, and Warne Clinic. He was a member of the President's Club at Jefferson. Survivors include his wife, Marion, of 199 Dock St., Schuylkill Haven, PA 17972, and two sons.

Norman Berger, '57 died April 29 at age fifty-nine. Dr. Berger had practiced family medicine. He is survived by his wife, Jane, of 200 N. Union St., Havre de Grace, MD 21078, two daughters, and a son.

Frank G. Wakefield, '70 died February 13. Dr. Wakefield had practiced radiology, and was a resident of Vero Beach, Florida at the time of his death.

Faculty

Gilson C. Engel, M.D., Honorary Associate Professor of Surgery, died April 6 at age ninety-two. Chief of Surgery at Lankenau Hospital from 1942 to 1964, Dr. Engel was an Emeritus Professor of Clinical Surgery at the University of Pennsylvania. He invented the Engel gastric pouch, used after complete removal of the stomach. With the late Hans May, he created the Engel-May two-plane direction and range finder for nailing broken hips.

Dr. Engel was a pioneer in public health education, speaking frequently on cancer prevention to various groups. He founded the Pennsylvania Health Council in 1949, and served as its President until 1953.

A past President and past Chairman of the Board of Trustees of the Pennsylvania Medical Society, Dr. Engel was a member of the House of Delegates of the American Medical Association for eighteen years. He served on the Judiciary Committee of the American College of Surgeons, and on the Board of Directors of Blue Cross of Greater Philadelphia.

He was a Fellow of the College of Physicians of Philadelphia and the Philadelphia Academy of Surgery, and an affiliate member of the Royal Society of Medicine in London.

Willard A. Krehl, M.D., Ph.D., Professor Emeritus of Medicine, died May 11 at age seventy-seven. Dr. Krehl had taught community health and preventive medicine at Jefferson. He was a past President of the American Board of Nutrition, the American Society for Clinical Nutrition, and the American Heart Association of Southeastern Pennsylvania. He had served as Editor-in-Chief of the *American Journal of Clinical Nutrition,* and as a member of the editorial board of *Nutrition Today.* Dr. Krehl was a Fellow of the College of Physicians of Philadelphia. He is survived by his wife, Beatrice, a daughter, and two sons.

Edwin M. Masters, Ph.D., Associate Professor of Anatomy, died June 14 at age fifty-nine. At this year's Class Day ceremonies, Dr. Masters received the Lindback Award for Distinguished Teaching in the Basic Sciences. He had served on the Promotions Committee, the Library Committee (which he chaired in 1980–81), the Committee on Animal Resources and Supporting Facilities, and the Geriatric Subcommittee of the Curriculum Committee. His research interests included cell culture, brown fat, and in vitro fetal lung development. Dr. Masters is survived by his wife, Sybil, of 19 Pebble Ln., Cherry Hill, NJ 08034, three daughters, and a son.

Michael L. Perrige, D.M.D., Clinical Instructor in Otolaryngology (Oral Surgery), died June 16 at age fifty-one. A board-certified oral and maxillofacial surgeon, Dr. Perrige was Chief of Oral Surgery at St. Agnes Hospital. Survivors include his wife, Anne, a daughter, and a son.

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